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SOCIAL CLASS AND MENTAL ILLNESS: A STUDY OF TWO BRISBANE SUBURBS

Alexander Gordon Pemberton
B.Soc.Stud., B.A.(First Class Honours)

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TABLE OF CONTENTS

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Signed: A. J. Pemberton

ABSTRACT

This thesis is a report of an Australian study of social class and mental illness. It is based on an investigation of two Brisbane suburbs - The Gap, a predominantly middle class area and Carina, a working class suburb. The data examined here are from two sources; a psychiatric morbidity census or enumeration of psychiatric patients from the two suburbs, and a questionnaire survey of samples of residents of Carina and The Gap.

In the first chapter of the report, some of the theoretical and methodological issues underpinning a study of class and psychiatric illness are tackled. Specifically, the particular approaches to 'social class' and 'mental illness' are discussed in some detail. In addition, the chapter provides a general introduction to sociological studies of psychiatric disturbance, and an overview of relevant research with special emphasis on published Australian work.

Chapter Two is concerned with a rationale for the project and a detailed account of the data gathering procedures (the psychiatric census and the social survey). The task in Chapter Three is to provide a description of Carina and The Gap, highlighting and contrasting their main social and demographic features - notably, the marked differences in socio-economic composition of their residents. The chapter concludes with a discussion of whether the survey samples were representative of characteristics of the suburban populations.

The next three chapters present an analysis of the data. Chapter Four examines the results of the morbidity census and it was found that Carina (the blue collar area) provided more than twice as many patients as The Gap (the mainly white collar suburb). However, when the cases were analyzed by the patient's socio-economic status there was no association between social status, and the frequency and type of mental disorder. Further, this finding - one which contradicts the overseas evidence - is supported by additional data from the sample survey of the two suburbs; there was no relationship observed between the respondent's social

status and whether or not they reported that anyone from their household had needed to seek medical help for a mental or nervous illness. The remainder of the chapter is an analysis of the relation between socio-economic status and the kind of treatment received by patients in the morbidity census.

In Chapter Five, there is an analysis of two aspects of the samples' responses to simulated cases of mental disorder presented in the course of the survey. Overall, the data revealed a low perception of the seriousness of the symptoms of psychiatric disorder and a low level of identification of mental illness. Recognition of mental illness (and perhaps the evaluation of the seriousness of symptoms) appeared to be related to the socio-economic standing of the respondent - the higher-up the social scale, the more likely were respondents to recognize mental illness in the fictitious cases. Respondent's knowledge about where to find psychiatric treatment (and help for marital and financial troubles) is discussed in Chapter Six. Generally speaking, the level of information among sample members was high; most respondents from Carina and The Gap said they would know where to seek psychiatric help (as well

as marital and financial assistance), and they were able to nominate specific and realistic facilities when pressed further for details. Knowledge about where to obtain help was related to socio-economic status (high status persons were the most informed), though this was only a relative matter - the majority of respondents from working class backgrounds said they would know where to find help if the need arose.

Finally, in Chapter Seven, the main findings of the project are reviewed and some of its limitations noted. Next, the implications of the findings for future research are considered and last, there is an assessment of the relevance of the study for the provision of effective psychiatric services.

CHAPTER I

SOME THEORETICAL CONSIDERATIONS

This is a report of an Australian study of some aspects of the relationship between social class and mental illness. In this chapter it is intended to introduce a number of the conceptual and theoretical issues underpinning the research project. The discussion opens with a few preliminary remarks and then moves on to a brief survey of the sociological study of mental illness. Next, some of the problems in the scope and methods of studies of the relationship between class and mental disorder are pursued, including a review of Australian research on this topic. The chapter concludes with a short discussion about the theoretical and methodological implications of the particular approach to social class adopted in this investigation.

INTRODUCTION

Despite the rapid growth and development of sociology in Australia, one of the outstanding areas of neglect has been in the field of the sociology of deviant behaviour. In keeping with this neglect of social problems and deviance by Australian scholars there has been, not surprisingly, little or no work

on the sociological study of mental illness.[1] Yet in this society it is obvious that the problem of psychiatric impairment is an immense and serious one, and there is abundant evidence to support this statement. For example, it is variously estimated that in Western industrial societies between one person in ten and one person in twelve will be hospitalized for mental illness in their life-time.[2] And referring to the Australian situation, a spokesman for the Mental Health Federation of Queensland recently stated that: "Few people would be aware that tonight one person in every 480 people in Queensland will sleep in a mental hospital bed... four people in every ten in the community are emotionally disturbed at any one time... more people are hospitalized for mental illness than for cancer, heart disease, tuberculosis and poliomyelitis combined."[3]

Australian research into the social aspects of psychological disorders has generally been the province of specialists in fields other than sociology - such as psychiatry and psychology.[4] This is a surprising situation because the overseas experience points to a

fruitful sociological contribution to the theory and practice of psychiatry. In this light it is worth looking briefly at the scope of theory and research in the sociology of mental illness.

THE SOCIOLOGY OF MENTAL ILLNESS

The sociology of mental illness has been characterized by a variety of concerns - epidemiological research, etiological studies, investigations of social factors in the treatment process and the social organization of the mental hospital. In fact, the sweep of interest of sociologists has been broad, embracing both 'macroscopic' studies of the influence of large-scale social processes and more 'microscopic' research, for example, on the interpersonal dynamics of psychotherapy as a social relationship. One of the enduring interests and most frequently recurring themes is the correlation between social class and mental disorder and probably the bulk of sociological work is in this area. It is now quite clearly established that socio-economic status is related to the amount and type of mental disorder in a community and the kind and quality of treatment received by patients.[5]

The present study takes up this issue, but before looking in depth at the relationship between class and psychiatry, something must be said about the term mental illness as it is used here.

Because it is marked by competing and conflicting points of view, the contemporary study of mental illness is one of the most exciting areas of investigation in the behavioural sciences today. Fundamental differences of opinion exist among scholars on such basic questions as 'what is mental illness'? In answer to that question, there are important disagreements that have crucial implications for any empirical study of psychiatric disorders.[6] A primary distinction may be identified between those who completely reject the traditional concept of mental illness as a disease and, on the other hand, those who accept the medical or disease model of psychiatric disturbance. Brief clarification of this point is needed.

Those who champion the first approach - notably Szasz, Laing and Cooper - may reasonably be described

as viewing the study of mental illness "as a pseudoproblem such as that of ether in yesterday's physics."[7] For Szasz it does not exist: in his own words, 'mental illness is a myth.'[8] He sees mental health as a kind of game, played to social rules, for which the crucial thing is the ability and fitness to play it well. Laing and Cooper would also jettison the term mental illness to describe certain behaviours which they prefer to call 'a different mode of living'. These authors go further and tie their understanding of the phenomenon to an ideological and polemical critique of their own society - for them, 'mental illness' is closely implicated with exploitation and oppression in modern capitalist society.[9]

The ideas of Szasz, Laing and Cooper have been greatly admired and few would doubt they have drawn attention to some important criticisms to be made of contemporary psychiatry. Szasz, for instance, has written of the dangers to civil liberties from the encroachment of psychiatry into more and more areas of personal life.[10] Similarly, Laing and Cooper have been concerned to publicize the implicit and often explicit violence done

to people in the name of 'psychiatric treatment.' Yet these authors have not escaped criticism of their own work; some say they put their case too strongly, while others make the charge that they are guilty of serious over-simplification and misunderstanding of the processes of psychological disturbance.[12]

The dominant perspective in modern psychiatry - and indeed, the approach followed in this report - is founded on the disease model of mental illness which is based on four main premises.[13] In the first place there is the concept of nosology, the idea that qualitatively different states of disorder of the personality exist and may be identified. Second, there is pathology or the notion of an illness process within the organism persisting over time. Third, there is etiology, the belief in a pernicious agent and a causal sequence. Fourth and finally, therapy or the belief that how the patient is treated makes a difference. However, even among those who subscribe to the medical model, there are substantial differences surrounding opinions about the

causes and proper treatment of mental disease. Some would assert the primacy of a single causal agent - either biogenic (genetic or biochemical), psychogenic or sociogenic:

> With the tremendous strides being made in neurophysiology, neurochemistry, and neuropharmacology, there is every reason to believe that the problem of mental disease can eventually be defined and dealt with in terms of purely biological concepts.[14]

The most widely supported position however, and one providing a better fit with the available evidence, is based on a multi-factorial approach to causation. A statement by J.M. Yinger on the etiology of schizophrenia will illustrate this approach clearly and, at the same time, indicate some of the methodological implications that follow from it;

> On the evidence to date, it seems reasonable to assume that variation exists in predisposition, whether of genetic, physiological, or chemical origin. It seems equally likely that schizophrenic tendencies are associated with certain kinds of stressful interpersonal experiences and with certain kinds of response from significant others to early manifestations of distress. At the moment it is difficult to go beyond eclecticism;

> but eclecticism seems wiser than the assumption that when the evidence is better, a genetic, neurochemical, psychodynamic, or sociocultural explanation will prove to be the decisive one... the task is to bring these several dimensions into one system so that the effects of their integration can be given full attention.[15]

To sum up, the position adopted in this report is that the weight of the evidence favours a view of mental disorder which, although it is presently only imperfectly understood, rests on the premises of the disease model: that is, it will be assumed here that mental illness exists and that it may be studied by the usual methods of the behavioural sciences. By way of emphasis and of direct relevance to the present study, it may be pointed out that the disease model of mental illness finds its expression in the so-called community mental health movement of recent times. Embracing the activities of both professionals and laymen, this movement includes the following concerns; educational programmes to disseminate information and to change attitudes towards mental abnormality, preventive intervention and encouragement to seek early treatment,

recognition of the emotional disorders as well as the grosser forms of impairment and, in general, an emphasis on social factors in psychiatry, particularly the fullest use of the wider community in all aspects of practice.[16] Having said that, it is now intended to return to the main theme by reviewing briefly the main trends in research on social class and mental disorder.

SOCIAL CLASS AND MENTAL ILLNESS: AN OVERVIEW

Perhaps the first study to recognize the association between class and psychiatric impairment was one by Faris and Dunham in 1939. This was an ecological investigation of the residential distribution of psychotic cases in the Chicago urban area. With respect to the distribution of schizophrenia, general paresis, drug addiction and alcoholic psychoses, these authors observed "the highest rates occurring in neighbourhoods characterized by low socio-economic status and rapid population turnover."[17] A later study, the famous "Social Class and Mental Illness" by Hollingshead and Redlich (1958), is generally regarded as a classic in this field. It provided the stimulus for

an extended series of investigations of the relation between psychiatric data and social status. Stated briefly, Hollingshead and Redlich found a relationship between social class and the type and prevalence of illness, the paths to treatment taken by patients, and the kind of treatment for diagnosed mental illness. They offer the following summary of their research:

> ...we have found that the New Haven community is characterized by a distinct class structure. Each class exhibits definite types of mental illness. Moreover, each class reacts to the presence of mental illness in its members in different ways, and the treatment of psychiatric patients within the various classes differs accordingly.[18]

Undoubtedly, one of Hollingshead and Redlich's major contributions was their general orientation to the problem of mental disorder as a socio-cultural phenomenon as well as a psychological one. They state; "The perception and 'appraisal' by other persons, of an individual's abnormal behavior as psychiatrically disturbed is crucial to the determination of whether a given individual is to become a psychiatric patient or be handled some other way... it designates how the

prospective patient perceives his actions, particularly his disturbed actions. Appraisal... entails how a disturbed person and his actions are perceived and evaluated by the individual and by other persons in the community. Appraisal will determine what is judged to be delinquency, bad behavior, or psychiatric troubles."[19] Thus Hollingshead and Redlich have made it clear that an important factor in the process of becoming a psychiatric patient is the recognition and evaluation of symptoms by the person, and especially, by significant others around him. This orientation is consonant with the dominant perspective in contemporary sociology - the societal reaction or labelling theory approach to deviance.[20]

Ten years later, the follow-up study of the patients identified by Hollingshead and Redlich has done much to confirm the original picture, by revealing class differences in treatment and readmission experiences, and class differences in the adjustment of former patients in the community.[21] The fruits of other studies of class and psychiatric impairment have emphasized the complexity of the issues involved - such as 'the problem of directionality' as Dohrenwend and Dohrenwend refer to it: "It is as

conceivable that a man's occupation, education, or income results from his psychological condition as the other way around."[22] Or, in other words, the frequently observed association of class with mental illness may very well be the effect rather than the cause.

Despite the need for caution and qualification in interpreting the correlation, Marc Fried was recently able to sum up the present position in these strong terms:

> The evidence is unambiguous and powerful that the lowest social classes have the highest rates of severe psychiatric disorder in our society. Regardless of the measures employed for estimating severe psychiatric disorder and social class, regardless of the region or the date of the study, and regardless of the method of study, the great majority of results all point clearly and strongly to the fact that the lowest social class has by far the greatest incidence of psychoses.[23]

As well, there are class differences in the social and professional responses to psychological malfunctioning -

> individuals from the lower social classes are more likely to be extruded and hospitalized, and more likely to receive more serious diagnoses and inadequate treatment.[24]

That is the American position, but the important question is to what extent do these findings apply in Australia? In short, very little is known about the problem here because of the paucity of empirical research. Further, the picture is clouded by the often contradictory findings of the studies which have been done. At the time the present project was undertaken (mid 1970), there were four principal Australian studies available of social status and mental illness. Each of these will now be mentioned briefly.

First, there was Cade's epidemiological study of schizophrenia, comparing the patterns of distribution of illness in metropolitan and rural areas of Victoria (1956). Concluding that there was "no relationship whatever between social and economic status or insecurity and frequency of schizophrenia", he turned elsewhere for a causal explanation: "Those towns with the lowest incidence were notable for the abundance of fruit trees in home gardens."[25]

Second, came the rather more promising 'psychiatric epidemiology study' of Sydney by Yeomans and Hay (1962).

On the basis of a sample of 300 cases drawn from the admission records of a local mental hospital and a status-ranking of Sydney suburbs, Yeomans and Hay concluded:

> ... the distribution of patients can be seen to be similar to the findings of other workers (Faris and Dunham, 1939). The greatest concentration of patients is in the lower, particularly "D" class, suburbs, and within those suburbs the distribution of patients is highest in the densely populated transitional and central city zones.[26]

This study at least tentatively establishes a relation between social status, areal distribution and psychiatric pathology in an Australian context.

Next, there was Krupinski and Stoller's very important investigation of the occupational backgrounds of first admissions to the Victorian Mental Health Department (1968). These researchers found a correlation between social standing and psychiatric impairment. There were "lower first admission rates for all psychiatric disorders in the 'Professional, semi-professional and managerial' group" and "higher first admission rates in the lower occupational groups." Krupinski and Stoller argued that;

> There is no doubt,[however] that the markedly higher first-admissions rates for alcoholism, schizophrenic states, and personality disorders in the 'Semi-skilled and unskilled workers' are reflections of the more frequent occurrence of these disorders in the lowest occupational groups.[27]

Finally, there was the thorough and careful health survey of the Victorian rural town of Heyfield by Krupinski, Stoller and others (1970). These researchers were concerned to document the nature and extent of physical and psychiatric morbidity in a single community. Although they failed to find an association between social status and mental illness, this may be explained at least in part, by the small total number of cases they identified.

> Contrary to other authors [they cite Faris and Dunham, Hollingshead and Redlich, and others] we were not able to demonstrate any association of psychiatric disorders with social class. We were unable to show a higher prevalence of schizophrenia in lower, and of manic-depressive illness in higher classes as there were only five persons with major psychiatric illnesses in Heyfield. Our findings do not support the views that psychoneurotic disorders occur to a greater extent in higher classes...[28]

From the synoptic account above of the completed Australian research, it can be seen that there was no clear picture available of the relationship between social class and mental disorder when this investigation began: few studies had been completed and these yielded something of a confusion of findings. As well, evaluation was made difficult by some important differences in methodology surrounding the measures of social class used, the assessment of psychiatric impairment and even the objectives of the investigations.[29] It was hoped that the present study would be a useful contribution in two ways. In the first place, it was hoped to gather accurate data on the class-mental illness issue by a Psychiatric Morbidity Census, a counting of cases of psychological disorder in two specific populations within a given time period. Second, it attempted to make up for the lack of Australian research on the social aspects of illness and treatment by tackling the following kinds of questions - do members of the community recognize the symptoms of psychiatric disturbance and would they know where to obtain treatment if they needed it?[30] Further, is recognition of the symptoms of illness and knowledge about where to seek psychiatric treatment related to the socio-economic status or other personal and

social characteristics of community members? Of course there will be restrictions on the generality of the answers to these questions provided by this study: because of the limitations of time and money, this project is modest in scope, it is confined to an investigation of two suburbs in a single Australian city - one a high status suburb and the other a low status area. Before describing the data gathering procedures and the characteristics of the two suburbs, it will be necessary to say something about the theoretical and methodological implications of the particular approach to social class used in this report.

SOCIAL CLASS: A NOTE

In a very important paper, Hyman Rodman has recently made a fruitful distinction between two approaches to the study of social class.[31] On the one hand, Rodman says, there is the 'realist' stance which is concerned with the investigation of three closely related aspects of the class question: class interaction or the social class as a group; class consciousness or awareness of class divisions and one's

membership in a social class; and class culture or the distinctive life styles of each of the strata. On the other hand, there is the 'nominalist' approach whereby the researcher sidesteps the issue of whether classes really exist. Rodman comments that

> Most recent research on social class uses a "nominal" definition. Studies that report findings on the lower class, working class, middle class, or upper class usually define class in terms of an index such as occupation, education, or income, or some combination of these indices.[32]

In this study, occupation - and very often education - is used as an indicator of social class, with ratings of occupational prestige or educational attainment forming an hierarchical order. As Rodman points out, this is quite a respectable procedure and by no means a novel one. Yet a number of critics, notably Hodge and Siegel and Raymond Murphy have recently emphasized some of the problems of this approach, therefore a brief rationale is required for its use here.[33]

In the first place, in an exploratory study like this one it provides information about the association between social class, nominally defined, and dependent variables such as recognition of the signs of mental illness or knowledge about psychiatric facilities. In the second place, it has ease of use to commend it by enabling cross-tabulations with a wide range of variables, to yield quantifiable and reasonably precise data. Third, the 'nominalist' approach is a flexible one, allowing cross-tabulation with various dependent variables to be made separately against both occupation and educational rank; this is a highly desirable step in the case of knowledge about where to seek treatment, for which it is important to ascertain not only the influence of occupational rank but also the effects of different levels of education. Finally, it is important to recognize that sociologists, and many others, have asserted the primacy of occupational roles in the determination of social class. "In 1911, the Chief Medical Statistical Officer in the General Register Office, T.H.C. Stevenson, used the concept of social class to arrange the British census data into five social classes. The basis of the division... appeared to be socioeconomic

ranking of occupations."[34]

As Susser and Watson have noted, such a system of classification has advantages in both comparative sociology and specifically, in the case of epidemiological research. At the same time however, they are aware of its shortcomings; the fact that a number of people with similar occupations are grouped together in broad categories does not necessarily mean they will act in concert in a class-conscious way

> Other factors cut across such broad categories: how people choose to spend their money, what religious beliefs they hold, what degree of education they have acquired, what political party they vote for, or what occupational aspirations they hold for themselves or their children... Because of the existence of status groups and status associations of various kinds, it is possible to construct a continuum of prestige based on any one of a number of criteria.[35]

Susser and Watson point out that while social class scales can be constructed to account for these complexities, occupation has been commonly used as a basis for ranking large populations by social class. This is partly because it is an objective criterion easy to establish and partly

because "it can be compared with other occupations within the same or a different community; and it provides one single criterion for socioeconomic class. For although a man's social standing and his patterns of health and disease may well vary according to the place where he lives, and the social standing of the persons with whom he interacts, his occupation often determines his income, his dwelling place, and his social standing, in sum, his socioeconomic position in terms of the whole society."[36] The case for the use of occupational rank as a measure of social class has been summarized well by Timms, when he says that

> Much evidence is available on the importance of occupation in the stratification system of urban-industrial society and occupational position is highly correlated with such other rank attributes as prestige, educational achievement, area of residence, and income... Occupational status may be regarded as the most important single attribute of social rank...[37]

There are good reasons then, for using occupation as the main measure of class and, in general, for taking a 'nominalist' stance with respect to the issue of social class. That is about all there is to say on the theoretical

underpinnings of this study. The task in the next chapter is to provide a detailed outline of the procedures followed in this investigation of class and mental illness in two Brisbane suburbs.

CHAPTER II

METHODOLOGICAL PROCEDURES

In this chapter it is intended to describe the research methods used in the present study. The chapter begins with a discussion about the background and development of the project and this is followed by a description of the design and execution of the Psychiatric Morbidity Census and the Survey.

THE BACKGROUND AND DEVELOPMENT OF THE PROJECT

From its inception this project has been a collaborative effort reflecting a variety of inter-disciplinary perspectives. Originally, the investigation was planned by Professor F.A. Whitlock of the Department of Psychological Medicine at Queensland University as a part of his ongoing work on suicide in Brisbane.[1] Early in 1970 Whitlock intended to study the social correlates of suicide and he had selected two Brisbane suburbs (Carina and The Gap) - one with a high and one with a low suicide rate - as the site for his research. At the

same time, Dr. Paul Wilson a criminologist in the Department of Anthropology and Sociology at Queensland University and the writer were planning a study of social class and social pathology in Brisbane. Preliminary discussions indicated the possibility of collaborative research and the pooling of joint budgets. In the two suburbs under consideration by Whitlock there were striking differences in the occupational and educational levels of the residents. A study of these suburbs, one 'high status' and one 'low status', would provide an opportunity for an exploration of the relationship between social class and social pathology (crime and mental illness) in an Australian context.

A combined project was agreed upon which would involve the sharing of research expenses and the pooling of data. Carina and The Gap were selected for the study which is concerned primarily with crime and mental illness; this report however focusses on the data on mental illness.

In selecting Carina and The Gap it was realized that they would not be representative of the total Australian

population or even of the population of Brisbane. The present work is obviously modest and limited in scope - for example it is confined to an urban population and it looks at only two suburbs in a single city. Thus it should be seen as an exploratory study of social class and mental illness. However, by investigating two suburbs, one with mainly white collar workers and the other predominantly a blue collar area, it is possible to maximize the influence of socio-economic status on mental illness in the population under study.[2] This kind of research strategy is appropriate in an exploratory study which seeks basic information and it is especially relevant in Australia where little systematic research has been done on socio-economic status and mental disorder.[3] By examining two suburbs with markedly different educational and occupational profiles it is likely that the influence of socio-economic variables on mental illness will be highlighted - if it is operating at all.

In this study data were collected from two main sources; a Psychiatric Morbidity Census and a Social Survey. In addition, some information was obtained from official collecting agencies such as the Commonwealth Bureau of Census and Statistics and the Queensland Public Library

and also from the Queensland Police Department. The first phase of the data collection began with the Psychiatric Morbidity Census, a counting of the cases of mental illness from the two suburbs between April 1970 and March 1971. The second phase commenced with the administration of the Survey during the months of August and September 1970. The division of labour in the project followed fairly closely along disciplinary lines. Whitlock, the psychiatrist, designed and conducted the Morbidity Census while Wilson and the writer, the sociologists, carried out the Survey. However there was close cooperation in design and planning throughout, particularly in the construction of the questionnaire used in the Survey. The principal research operations used in the study, the Census and the Survey, will now be described in some detail in the succeeding sections of this chapter.

THE PSYCHIATRIC MORBIDITY CENSUS

The prototype of the Census used in this project is the morbidity survey carried out by Hollingshead and Redlich in the New Haven (U.S.A.) metropolitan area and reported in their ground-breaking monograph on social class

and mental illness.[4] Briefly, these authors set out to enumerate all persons from New Haven who were being treated by a psychiatrist or under the care of a mental hospital or psychiatric clinic during a specified time. Although the Hollingshead and Redlich research was conducted in the early 1950's it provides the guidelines for the present study. The aim here was to obtain accurate information about persons from Carina and The Gap who were being treated for mental illness within the twelve month period from the beginning of April 1970 to the end of March 1971. In describing the procedures used in the Brisbane study it will be necessary to begin by outlining the definition of a 'case' and then to indicate the specific steps followed in gathering the data.

Three factors were of central importance in determining whether a case was included in the Census. These were; where the patient was treated, by whom the patient was treated and the patient's suburban residence. During the specified time period; any person in treatment with either a psychiatrist or a general medical practitioner for mental illness, or attending a psychiatric clinic or

other out-patient service where psychiatric help was available or in a mental hospital, who was at that time a resident within the official local government areas of Carina and The Gap was, for the purpose of this study, a 'patient'.

The major concern was to gather systematic and accurate information about the psychiatric populations of the two suburbs. The first step then, involved making a list of all of the places at which persons from the two suburbs might appear for treatment; these were broadly categorized as individual professional practices and government hospitals and institutions. The list began with the general medical practitioners from Carina and The Gap - there were six listed as practicing in each suburb - and the eighteen private psychiatrists working in the Brisbane metropolitan area. Each of them received a letter from Professor Whitlock briefly explaining the purpose of the study and requesting their cooperation. None of the psychiatrists refused to take part, although not all of them contributed any patients to the survey. It is of course possible that some of these psychiatrists

had cases from Carina and The Gap and just forgot about them, or that they did not want to break the confidentiality of the relationship with their patients by including them in the study. Among the general practitioners there was a single refusal (from Carina) which, it turned out, was the only instance of non-cooperation encountered in the Census. All of the general practitioners who took part supplied patients' histories for the project.

Listing the Government facilities that could be used by persons seeking help for mental illness was slightly more difficult. Within the Brisbane metropolitan area there are a variety of Commonwealth and State government hospitals and institutions offering psychiatric services. Carina and The Gap are on opposite sides of the Brisbane River which effectively divides the metropolitan area for the purpose of medical services; each side is served by a large general public hospital with a range of medical and psychiatric facilities, both in-patient and out-patient. The principal psychiatric facilities however, are a large centrally located out-patient clinic and a large chronic mental hospital situated outside the city, both are State government institutions. As well, psychiatric help in Brisbane can be

obtained from two Commonwealth Repatriation hospitals for ex-servicemen, from two institutions specializing in child psychiatry and from two other hospitals within the metropolitan area.[5] Whitlock's introductory letter was sent to the Superintendents and Directors of all of these hospitals and clinics, explaining the morbidity study and requesting their cooperation. All of these institutions participated and all of them supplied patients. Obviously the success of the Psychiatric Census depended, to a large degree, upon the amount of cooperation from the individual practitioners and psychiatric agencies. Their response was excellent and it is felt that the morbidity survey was a thorough and systematic coverage of the possible avenues through which residents of Carina and The Gap could find psychiatric treatment.

However, it should be recognized that the Census may have underrepresented the psychiatric patient populations from Carina and The Gap in at least two ways. First, there were almost undoubtedly people suffering from mental illness who were being treated by non-medical therapists such as social workers in welfare agencies and clergymen in pastoral counselling. To catch these people it would have meant casting the net much wider and relying on a diagnosis of

mental illness from people who are not specialists in that field. It is impossible to gauge accurately the size of this group; even though it should certainly not be overestimated it quite likely includes a number of people suffering only a moderate or minor degree of psychiatric impairment. Second, as Hollingshead and Redlich[6] have pointed out, some people, especially those who are financially well-off may go 'out of town' - in this case perhaps to another suburb, another town or even inter-state - for their psychiatric treatment. Once again, while there is no information available to judge how many are involved here, it is likely (though of course this is really speculation) that the numbers will be small or even negligible.

In the Census, the data about each patient were recorded on separate sheets of a patient schedule or pro-forma questionnaire.[7] The questions on the patient schedule were pre-coded in the form of a simple check-list which was divided into two parts;[8] personal or demographic information and psychiatric diagnosis. On the first part, personal details were recorded to enable the patient groups

to be cross-classified by their demographic characteristics - sex, age, marital status, occupation and length of residence in the suburb. As well, it included some information to identify where the patient was located in treatment and their suburban residence (Carina or The Gap). On the second part of the schedule there was a list of twenty-one diagnostic categories based on standard psychiatric nomenclature and adapted by Whitlock especially for the Census; for example, schizophrenia, anxiety state, dementia associated with old age, and so on (see Appendix 1).

Some observations are in order about the problems posed by the occupation question on the pro-forma. In a paper dealing specifically with the difficulties of using an occupational ranking in the study of mental illness, Krupinski and Stoller state that:

> Occupation by itself is (however) not sufficient to ascertain the social class status of psychiatric patients.[9]

Their principal objections are: that it is not a useful measure for working and non-working women, working adolescents, students and children (and it may be added, pensioners too), and that low occupational status is often the

consequence rather than the cause of mental illness, especially in the case of schizophrenia. Krupinski and Stoller suggest that it would be "more appropriate to ascertain the social class status of the whole family,"[10] and they advocate the use of composite indices of class including measures to account for the (downward) occupational mobility of the mentally disturbed at a generational and an individual level.

To these problems a further difficulty may be added. The experience of survey research has made it clear that to obtain an occupational ranking or hierarchy, detailed and specific information is necessary about each occupation. This requires full and precise instructions to respondents who must be told to write, for example, "senior clerk in the public service" or "owner of a one man mixed business" and not merely "clerk" or "business man".[11]

In the morbidity survey it was felt that one important factor in securing cooperation from the already overworked psychiatric agencies and practices would be to make the patient schedule as brief as possible. While recognizing the validity of Krupinski and Stoller's arguments, the

practical requirements of the project demanded a questionnaire with the minimum number of items, one that could be completed quickly and easily. Consequently, the occupation question simply asked for the patient's occupation, with the rider that if the patient was a housewife, to record the husband's occupation which in those cases would be used to calculate occupational status. However it is important at this stage to have pointed out some of the limitations of the occupation question used in the Census. This problem will be brought up again at some length in the discussion of the results of the Morbidity Survey in a later chapter of this report. The present study, it should be remembered, is an exploratory one and it will be the task of subsequent larger, more generously financed projects to deal with the considerable problems of obtaining a more adequate index of class in psychiatric morbidity studies.

The actual data collection process in the Census was carried out by Professor Whitlock's research social worker specially employed for that purpose. Pro-formas were left with the individual practitioners (the private psychiatrists and suburban doctors) and these were either collected periodically by the social worker when they were filled in or

completed and returned by mail to Professor Whitlock. Data collection from the hospitals and clinics required that the social worker make regular and systematic enquiries - several times each week in the really busy agencies - to catch any patients from Carina and The Gap. In these cases the details were recorded by the social worker from the case notes and files. It is worth mentioning that with the huge volume of patients seen in the hospital outpatient facilities and casulty departments, and the problems of searching through voluminous case-histories, it is possible that a few persons from Carina and The Gap were overlooked by the survey.

One possible source of error in the Census was the 'double-counting' of cases. That is, persons in treatment at more than one place or returning to the same place for treatment after a time lag, being counted twice. Precautions were taken to avoid this by gathering sufficient identification data (for example, the street in which the patient lived, age, sex, occupation, diagnosis and so on) to enable a check to be made of the pro-formas to ascertain which cases had been counted more than once. This procedure was, in fact, carried out a number of times and some instances of double-

counting were discovered and altered. A general rule was followed that if a person was located in more than one place he would finally be counted as being treated in the place which offered the most specialist psychiatric care (at a psychiatric clinic rather than with a medical practitioner or with a private psychiatrist rather than at the casualty department of a general hospital) and where, therefore, the most reliance could be placed on the diagnosis. Also, it was during these checks that careful attention was paid to the exact addresses of the patients to ensure that only those from within the official local government areas of Carina and The Gap were included. This lead to the rejection of a number of the pro-formas of patients from residences outside the suburban areas.

All the data from the Psychiatric Morbidity Census presented in this report were hand tabulated from the patient schedules in the form of frequency distributions and cross-tabulations. The data has subsequently been punched onto IBM cards for computer analysis at the direction of Professor Whitlock.

THE SURVEY

The second of the two main methods of data collection was the questionnaire Survey of Carina and The Gap. In the design of the project the Morbidity Census and the Survey were seen as complementary methods of gathering data about the suburbs. The Survey schedule was concerned with two broad areas - criminality and mental illness, though it is the latter field that will occupy the discussion here. Briefly, the principal topics dealt with in the questionnaire were: opinions and knowledge about mental illness; the patterns of use of, and knowledge about treatment facilities, the prevalence of mental illness in the two suburbs and the respondents' experiences with mental disorder and, personal and demographic information about the respondents, their families and their suburb.

THE PILOT STUDY At this stage it is pertinent to make some remarks about the pilot study conducted prior to the main survey. In social survey work, particularly studies of controversial or sensitive subjects, pilot projects or 'pre-tests' are essential.[12] Within the context of the present

research the pilot run was valuable for two reasons. In the first place, the questionnaire dealt with highly personal and emotionally charged issues such as the respondent's experiences with crime and mental illness. The pilot study, twenty or so interviews conducted by the writer, provided an opportunity to gauge the general feasibility of a survey dealing with such threatening (i.e. anxiety provoking) material. From the outset it became apparent that with careful and sympathetic interviewing, the majority of people encountered in a survey would be willing to talk openly and frankly about such things as the crime rate in their neighbourhood and whether anyone from their household had been treated for mental illness.

In the second place, the pilot study was an opportunity to evaluate the form and content of specific questions. One group of items that came under scrutiny was a set of open-ended questions designed to tap the respondents' understanding of terms like 'mental illness' and 'nervous breakdown'; a couple of examples will serve to indicate the nature of these:

When you hear someone say that a person is mentally ill, what does that mean to you?

As far as you know, what is a nervous breakdown?

It was felt that, with the paucity of research on the topic in Australia, these unstructured questions would be a suitable way of exploring public attitudes and knowledge about mental abnormality, and particularly, their 'commonsense' definitions of these concepts. However, a careful look at the answers to these and other free-response questions revealed that there seemed to be no systematic pattern to the responses. With no theme emerging from their answers, it appeared that respondents were replying in a random fashion and, because of the limits of space on the interview schedule it was decided to drop these questions in favour of a more structured approach. Another reason for the pilot study was to assess the utility of a technique for studying opinions and knowledge about mental illness with simulated case-histories. This method has been used extensively in research overseas - especially in the U.S.A. - and the pilot interviews demonstrated that the case vignettes, adapted especially for the Australian public, would work satisfactorily.

All in all, the pilot run was an invaluable prelude to the main survey. On the basis of it, some questions were added and some dropped, the length of the questionnaire and order of the questions was settled, and the general layout of the schedule was determined.

THE SURVEY Discussion of the Survey will involve a description of the questionnaire and an outline of the procedures used in the collection of the data and in data processing.

The Questionnaire. The interview schedule, which took about three-quarters of an hour to administer, dealt with the following broad areas.[13]

(1) Attitudes to, and the recognition of mental illness.
(2) The respondents' experiences and contact with mental illness in family, friends and acquaintances.
(3) Whether respondents had experienced problems in their lives, what kinds of problems they had encountered and what they had done about them.
(4) Knowledge of community helping services (psychiatric, marital guidance and financial).
(5) Variations in crime reportability (not discussed in this report).

(6) Detailed personal and demographic information about the respondents, their families and their suburb.

The items used to study attitudes to and the recognition of mental illness require special mention. These were simulated case-histories of mental disorder originally developed by Shirley Star (of the National Opinion Research Centre, 1955) with psychiatric consultation, for the purpose of ascertaining whether or not the public are able to recognize certain symptoms and disturbed behaviours as mental illness.[14] They have been used subsequently by a number of investigators both overseas and in Australia;[15] however, the original protocols have been modified for use in an Australian context by a study done in the Department of Psychological Medicine at Queensland University.[16] The eight simulated case-abstracts used in the present research were not meant to be exhaustive of the range of psychiatric pathology: they cover, however, such entities as severe psychosis with overtones of violence and unpredictability (paranoid schizophrenia), the emotional disturbances (obsessional neurosis), as well as the less spectacular but none-the-less debilitating disorders like simple schizophrenia, dementia associated with old age and the drug and alcohol dependencies.[17] The case vignettes, in

the order in which they were presented, are as follows:

(i) Mr. A is a married man of 35 who has a responsible clerical job. For some months now he has felt compelled to repeatedly wash his hands, although he realizes that he is doing this to excess. He has washed his hands so much that they are sore, and the family complain that they can't get into the bathroom. (Compulsive neurosis)

(ii) Mr. B is a 40 year old clerk who lives by himself in a flat. He has always been rather shy. Over the past few months, his employer has noticed that Mr. B has become very quiet and suspicious. He talks of a plot of some kind and says the police are watching him. A couple of times he has punched people who didn't even know him, because he thought that they were plotting against him. And often he sits idle at work, staring in front of him. (Paranoid schizophrenic)

(iii) Mr. C is a middle aged business man. He has always needed sleeping tablets, but lately he takes 3 or 4 to get a good night's sleep and he takes a few during the day "to steady his nerves". (Drug Dependence)

(iv) Mr. D is a widower, aged 81 years, who has lived with his married son and his family for several years. Recently, he has been going for walks on his own and getting lost, and the police have brought him home. His family realize that sometimes he thinks he is living in the past, and doesn't remember things at all well. (Dementia associated with old age)

(v) Mr. E is a single man in his twenties, living with his parents. He never holds a job for long, and doesn't seem to worry about looking for work. He is a very quiet person who doesn't talk much to anyone, even his family. He acts like he is afraid of people, especially young girls his own age. He doesn't go out with anyone and when people come to visit he stays in his room until they go. He prefers to stay by himself and daydream, or listen to the radio in his room. (Simple Schizophrenia)

(vi) Mr. F is 50 years old. He has always been happily married and has a healthy, grown up family. For many years he has been active in church work but lately is very upset because he feels he has lost his Faith. He has not slept well for many weeks because he is so unhappy. He eats very little and is losing weight. He

blames himself for his present misery and insists he is a worthless man. (Endogenous Depression)

(vii) Mr. G has a good job and is doing quite well at it. Most of the time he gets along all right with people, but he loses his temper if things go wrong or if people criticize him. He worries a lot about little things and he seems to be moody and unhappy all the time. Everything is going along well for him, but he can't sleep at night, brooding about the past and worrying about things that might go wrong. (Anxiety Neurosis)

(viii) Mr. H is 40 years old. He never seems to be able to hold a job for very long because he drinks so much. Whenever he has any money he goes on a "bender", and doesn't seem to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again. (Alcoholic)

Each case abstract was presented to respondents, one at a time, on a separate card.[18] Following each card the respondent was required to answer a series of questions about the case description. Two points, one about the order of presentation of the cases and the other, about sex of the persons shown in the vignettes, will be briefly mentioned.

It is well known in opinion research that the order of presentation of questions may influence the answers. In this study, however, the case-histories were delivered in the same order to all respondents because previous research has demonstrated that no order effect is operating with these items.[19] Further, studies using these case-histories have varied in the number presented and with respect to the sex of the persons depicted - for example Dohrenwend and Chin-Song use six abstracts (4 males and 2 females) and Graves et.al. use four (3 males and 1 female). However, as Phillips and Segal point out there is some evidence to suggest that the sex of the person in the case being evaluated is likely to be an important variable. Consequently, to avoid the confounding effects of sex upon the other dimensions of the

evaluation of the cases (e.g., diagnostic type) all the persons in the abstracts were given the same sex (male).[20] It will be the task of future studies in this field to explore the effect of sex on the evaluation of abnormal behavior.

Data Collection. Two aspects of the data collection process will be described; first, the briefing and training of the interviewers and second, there will be a detailed discussion of the field procedures (i.e. selection of the samples).

Obviously the manner in which the interviews were conducted could be expected to have a considerable influence on the quality of the data. Community surveys of mental illness depend to a large extent on the skills of the interviewers and this topic usually receives a good deal of attention in field work reports (see for example, Krupinski, et.al., 1970 and Krupinski and Stoller, 1971).[21] The financial limitations of the present project restricted the recruitment of interviewers to students only; however, where possible medical students and those with some training in the social sciences were used. The pilot interviews had demonstrated that a serious and reassuring manner during the interview would ensure the cooperation of most respondents,

even on the very personal questions. An important task of the briefing session, then, was to impart to the interviewers the need for this kind of an approach to the interviewing situation. The training of interviewers included trial interviews and instructions on the phrasing and delivery of specific questions. Each interviewer was equipped with a manual containing detailed instructions about interviewing techniques and the selection of respondents.

Turning now to the selection of the samples from Carina and The Gap, it is important to understand this in the light of what Jerome Manis has called 'extra-theoretical factors' in his perceptive paper on the sociology of mental disorders.[22] Writing specifically about community mental health research, he argues that most projects are shaped significantly by factors outside the researcher's theoretical framework. This study was no exception. The original plan was to draw random probability samples of respondents from the two suburbs, which, according to the Bureau of Census and Statistics estimates (from the 1966 Census), had approximately one and a half thousand dwellings in each. However, at the time the study was planned, two events occurred which suggested that there would be considerable difficulty in obtaining adequate-sized random samples. The first was a

lengthy and bitter controversy publicized in the mass media about the invasions of privacy from social surveys and door-to-door salesmen. The second event was the startlingly high non-response rate obtained in a survey of a random sample of the public, conducted by social scientists at Queensland University. This was due, it was believed, to unfavourable mass media publicity about surveys, and about student demonstrations and the University in general. Consequently, because of the effects of the expected high non-response rate on a random sampling probability design and the fear of obtaining insufficient interviews, an alternative approach was used to maximize the number of completed interviews - quota sampling methods. This latter approach has been developed by public opinion polling organizations (for example, The Gallup Poll) and used successfully in Australia in social science research.[23] In addition, as Galtung points out, it is a particularly useful tool in exploratory research - such as the present project - where the formulation and generation of hypotheses (rather than the testing and evaluation of them) is the task at hand.[24]

In this case, the following procedure was used. Each interviewer was assigned to a street-block within a suburb,

with instructions to begin interviewing at a specified place on that block and to work clockwise around it. Only persons between twenty-one and seventy years of age were to be interviewed. In order to maximize the size of the samples, interviewers were instructed to obtain as many interviews as possible on their assigned block, but to make only one interview per household. Most important, interviewers were told to obtain a balance across sex and age categories and they were given a card on which, at the conclusion of the interview, they recorded the age and sex of the respondent. The relevant instructions in the Interviewer's Manual read:

> It is very important for the survey that we have the correct proportion of males and females in the population and the correct distribution of age. Try to interview about equal numbers of males and females. In your early interviews ask for the youngest man over 21, or, if no men are at home, ask for the youngest woman over 21,... if you find from your card you have something of an age or sex imbalance in the interviews you obtain, ask specifically for age and sex groups in which you do not have sufficient interviews. But do not forgo an interview in any household if there is a possibility of somebody cooperating.

Records were kept by interviewers of the number of calls made, the addresses of the calls and, where applicable, the reasons for not obtaining interviews, as well as a list of

addresses of all persons interviewed. This enabled checks to be made to ascertain that all interviews claimed were valid. Finally, interviewers were encouraged to work during the evenings and week-ends when it would be most likely to find the whole family - especially working males - at home, and they were told to make as many 'call-backs' as possible when people were not found at home on the first attempt.

In short, the quota sampling technique employed here was intended to secure samples from Carina and The Gap that were as large as possible, in view of the expected high non-response rate, but which were representative of the characteristics of the two suburbs.[25]

A discussion of the characteristics of the samples and how closely they mirror the features of the suburbs from which they were chosen, will be postponed until the following chapter. The response rate obtained in the Survey however, should be mentioned here (see Table 2.01 for details). A total of 1,096 interviews were completed in the two suburbs.

TABLE 2.01

RESPONSE RATE

SUBURB	Total Completed	Total at home
Carina	500 (62%)	799
The Gap	596 (73%)	818
	1096	1617

At Carina, interviewers visited 1,145 dwellings and obtained interviews in 500 households out of the 799 dwellings in which eligible persons were at home; a response rate of 62%. At The Gap, 1,188 households were approached and 596 interviews were conducted in the 818 homes in which eligible persons were found (a 73% response rate). A word is in order about the non-response rate which appears to be somewhat higher than usually reported in survey work.[26] It is suggested that the main reason for this was the unfortunate conjunction of two sets of circumstances around the time of the project;

the widely publicized, heated mass media controversy about social surveys as invasions of privacy, and the low regard in which students and the University in general are held by the Queensland public following a series of unfavourable press reports of demonstrations by student radicals.[27] Clearly this level of non-response in the Survey will restrict the generality of the findings and it will require that cautious interpretations be made of the data in the analysis that follows. But it should be kept in mind that the present research is basically exploratory - concerned with the identification and formulation of relationships - rather than a definitive study of social class and mental illness in Australia.

Two final points are worth pursuing. The first one is, how reliable is the variety of information provided by the Survey about such an emotionally charged issue as mental illness? An answer to that question requires a follow-up study to test the stability of the responses over time and that is beyond the scope of the present project. However, a study by Hochstim and Renne - using a follow-up questionnaire - indicates that the reliability of socio-medical data obtained in a survey is, overall, very high.

They found the reliability of objective, factual information to be higher than for attitudinal or opinion data on medical matters.[28] This (high) reliability may well be due to the ego-involving nature of the subject matter: all people are interested in their own health. In fact, this approach was emphasized during the interviewing; the Survey was introduced and described to respondents as "a study of community health problems and services".

The second point is that the present study is essentially a preliminary investigation designed to explore the relationship between social class and mental illness in Australia. It attempts to determine some of the relevant sociological and demographic factors to be pursued in more detailed and comprehensive research in the future. Because of this, the data obtained in the Psychiatric Morbidity Census and the Survey are not subjected to statistical tests of significance but instead they are examined, through cross-tabulations, for trends and relationships to be followed by more sophisticated and rigorous statistical analyses in future research.

Data Processing. The completed questionnaires were edited and coded onto computer data sheets, then the information was transferred to punch cards and finally to magnetic tape. Data analysis was carried out on the GE225 computer at Queensland University by standard programmes (for frequency distributions, cross-tabulations, and correlation matrices) from the Department of Anthropology and Sociology.

SUMMARY

The principal methodological operations used in this project, the Psychiatric Morbidity Census and the Social Survey have been outlined in this chapter. In addition to the discussion of the steps involved in the data collection, some attention was paid to the problems encountered and the limitations of the study. The next chapter looks at the social setting of the project, the features of the two suburbs selected for the study.

CHAPTER III

THE SOCIAL SETTING

The social setting of the study will be described in this chapter, and then characteristics of the Survey samples will be compared with features of the two suburbs from which they were taken. The discussion opens with some introductory remarks about Carina and The Gap and these are followed by detailed demographic information which provides a factual basis for comparisons of the two suburbs. Finally, there is the question; how representative are the Survey samples? To answer this, the samples are matched with characteristics of the two suburbs - age, sex, religious affiliation, occupation and education.

THE TWO SUBURBS

The two suburbs selected for this study are part of the metropolitan area of Brisbane, the capital of Queensland. In 1966, the total population of Brisbane was 656,222 (Bureau of Census and Statistics figures).[1]

The city territory extends over a wide area with a low population density (812 persons per square mile), most families residing in single family dwellings. Carina and The Gap, which are described by the Bureau of Census and Statistics as south and north side outer-suburbs respectively, are situated about equidistant from the city centre. A brief history will be given of each of them in turn.

CARINA[2] Carina is a working class suburb with a population in 1966 of 6,682, while the population density, 1,662 persons per square mile, is relatively high compared to the figure for the total Brisbane area. Carina was developed by the Queensland State Housing Commission as a low-rental, low-cost housing estate. Although its origins may be traced back as far as the 1870's, the suburb experienced its most significant growth with the beginning of the Housing Commission project in the early 1950's which has continued to the present time. To date there has been approximately 800 Housing Commission dwellings constructed, which represents slightly less than half of the total houses. The result is a rather undistinguished place - flat and treeless - with a few clusters of small shops breaking the rows of houses which

have a monotonous sameness. Lacking any clear-cut 'territorial boundaries', Carina simply merges into the surrounding suburban sprawl.[3] A recent addition is a private enterprise housing estate on the outskirts of the suburb which has some of the most expensive land and houses in Brisbane.

While Carina has a rather unappealing physical appearance, there is, however, a variety of voluntary associations and other outlets for leisure activities that characterize Australian suburban life. Some of these are; a Bowling Club, Olympic Swimming Pool, Pre-School Centre, Municipal Library, the Carina Recreation and Pastime Club, the Carina Welfare (i.e. "progress") Association, and, of course, churches of various denominations.

THE GAP[4] Unlike Carina, The Gap has distinct boundaries; it is tucked away 'in the gap' between two sets of mountain ranges bordering Brisbane. A series of private enterprise housing developments has fostered a distinctly middle class atmosphere. Dwellings - in a variety of architectural styles, some quite attractive - are on hilly, spacious semi-rural sites. Boskoff's description of the 'identity-conscious suburb' will serve to indicate something of the flavour of The Gap:

> The major feature or tone seems to be one of recently acquired or desired upward mobility... with a pervasive distaste for the central city... In general, residents are in professional and managerial occupations... The residential character of the area and the maintenance of relative status homogeneity are prime considerations.[5]

The Gap too, can trace its beginnings back to the 1870's, though the most significant increase in population occurred in the late 1960's and is presently sustained. The population of The Gap is 5,764 (1966 Census figures), with a relatively low population density (794 persons per square mile) compared to the total Brisbane area.

At The Gap there is a wide range of voluntary organizations offering opportunities for participation and social interaction. These include; a Soccer Club, Scouts, Progress Association, a local Lions Club, two Pony and Riding Clubs, a Golf Club and a Country Club - the last three very much characteristic of a middle class, identity-conscious suburb and in marked contrast to the facilities at Carina. As well, there are the various denominational churches.

Following this brief sketch of the suburbs some detailed information will be presented to enable more precise comparisons to be made. First, some data from the 1966 Census (Table 3.01).

TABLE 3.01

COMPARISON: CARINA AND THE GAP

		Carina	The Gap
Total Population	Male	3355 (50.2%)	2978 (51.6%)
	Female	3327 (49.8%)	2786 (48.3%)
	1966 Census	6682	5764
	1970 estimate	7650	8300
Age (percentage)	0-4 years	11	18
	5-9	13	9
	10-19	24	15
	20-34	18	29
	35-54	24	15
	55 years and over	9	10
Occupation* (percentage of males in male workforce)**			
	Professional	4	15
	Managerial-Executive	7	15
	Clerical-Sales	19	29
	Skilled Manual	30	22
	Semi-skilled Manual	17	6
	Unskilled Manual	22	9

*This occupational classification follows the scheme suggested by Broom, Jones and Zubrzycki;[6] it involved hand-tabulation of the 1966 Census occupational figures for the suburbs.

**The figures for The Gap exclude a small proportion of the male workforce engaged in rural and semi-rural occupations.

		Carina	The Gap
Education (highest level attained - percentages)			
Never went to school and Primary school only		60	52
Other secondary		20	16
Intermediate		16	21
Leaving		3	6
Other tertiary		1	4
University		0.3	2
Religion (percentages)			
Roman Catholic		29	23
Church of England		33	33
Methodist		10	12
Presbyterian		10	13
All other, none and no information		18	19
Households			
Total	1966 Census	1666	1493
	1970 estimate	1929	2275
Type of Dwelling (percentages)			
	Owner occupied	64	93
	Tennant (Government)	30	0.4
	Tennant (other)	6	8

The data presented in Table 3.01 reveals the following information about the two suburbs. Although the 1966 Census population figures show that Carina was the larger of the two suburbs, the 1970 Census estimate suggests that The Gap is now bigger than Carina, and growing at a faster pace. There are differences in the age distributions of the two suburbs; The Gap has a large proportion of its adult population between the ages of 20 to 34 years, while the largest proportion of Carina adults are between 35 and 54 years of age. These differences are reflected in the age distributions of the younger residents of the suburbs. The Gap has more young children from 0 to 4 years whereas Carina has the highest proportion of older children and adolescents in the 10 to 19 years range. The proportion of elderly people in each suburb is about the same.

The most striking differences between the suburbs are in their occupational and educational profiles. Clearly, Carina is a blue collar suburb with approximately half of its male workforce employed in manual work. There are, however, a number of white collar workers at Carina; some 19% of the male workforce are employed in clerical and sales jobs and 11% work in professional or administrative positions.

On the other hand, The Gap is predominantly a white collar area. Thirty percent of the male workforce are professional and managerial or executive workers, and 29% are in clerical and sales occupations. Twenty-two percent are engaged in skilled manual work and a further 15% in semi-skilled and unskilled jobs. Moreover, these differences between the two suburbs persist with the levels of education attained by the residents. At Carina, 60% of the residents have either never attended school or have not gone beyond primary school, the corresponding figure is 52% for The Gap. Some 6% of The Gap residents have received tertiary education, while slightly more than 1% only, at Carina, have had a tertiary education.

There are few differences in the religious affiliations of the residents in the two suburbs, the main one is that Carina has a higher percentage of Catholics 29%, compared to The Gap, 23%.[7] Finally, it can be seen that The Gap has a much higher proportion of owner occupied homes than Carina; the figures are 93% and 64% respectively. Similarly, some 30% of the dwellings at Carina are occupied by tennants in government premises, while only 0.4% fall in this category at The Gap.

To broaden the picture of the two suburbs, data obtained in the questionnaire Survey are presented below.[8]

TABLE 3.02

COMPARISON: CARINA AND THE GAP

	Carina	The Gap
Length of Residence in Neighbourhood (percentages)		
Less than 12 months	10	13
1 - 2 years	16	21
3 - 5 years	20	23
6 - 10 years	17	26
Over 10 years	37	17
No answer, D.K.	0	0
	(500)	(596)
Satisfaction with their Neighbourhood (percentages)		
Very satisfied	43	76
Satisfied	43	21
Neither satisfied nor dissatisfied	6	2
Dissatisfied	6	1
Very dissatisfied	2	0
No answer, D.K.	1	0
	(500)	(596)
Home Ownership (percentages)		
Own home	20	25
Buying, paying off	57	70
Renting	20	5
No answer, D.K.	3	1

The data in Table 3.02 highlight some interesting differences between the suburbs. First of all, the trend is for Carina respondents to have resided longer in their suburb. Thirty-seven percent of Carina respondents said they had been at Carina for over 10 years, compared to 17% from The Gap who had been resident for a similar length of time. And fifty-seven percent of respondents from The Gap have lived there for five years or less compared to 46% for the Carina sample. As well, 43% of Carina respondents had never moved from their present place of residence - the figure was only 24% for The Gap (this information is not reported in tabular form, see Questionnaire in the Appendix). Second, Carina residents were less likely to be satisfied with their neighbourhood than residents of The Gap. Seventy-six percent of respondents from The Gap claimed they were very satisfied, while the figure was only 43% from Carina. Similarly, 8% of Carina respondents and only 1% from The Gap were dissatisfied or highly dissatisfied. A question on the interview schedule revealed differences between the two suburbs in the patterns of home ownership. Twenty percent of the Carina sample and 5% from The Gap were renting their homes, whereas respondents from The Gap were more likely than those from Carina to either own their homes or to be making mortgage repayments.

Finally, to complete the comparison some data are presented from the Survey, about participation in voluntary associations and whether the respondents own cars, television sets and telephones, and whether they receive the daily papers (see Table 3.03 for details).

TABLE 3.03

COMPARISON: CARINA AND THE GAP

	Carina		The Gap	
Voluntary Association Membership (percentages)				
Social Clubs	Head of household	Spouse	Head of household	Spouse
Regularly	35	25	38	29
Frequently	9	8	17	13
Never	50	51	45	51
No answer	6	16	1	7
Trade Unions and Professional Organizations				
Regularly	13	3	13	3
Frequently	8	1	13	2
Never	67	72	69	83
No answer	12	24	5	12
Household Facilities (percentages)	Yes		Yes	
Telephone	60		80	
Daily papers	85		91	
Car	86		93	
Television	91		91	

Once again, some interesting differences emerge between the suburbs. Turning first to voluntary association membership, it can be seen that the levels of participation vary by suburb, by marital status and by the type of organization. In both suburbs there were higher rates of participation in social clubs than in trade unions and professional organizations. Participation in voluntary associations was highest at The Gap, and this held for marital status - heads of households were more frequent participators than their spouses - and for the type of association, both social clubs and professional organizations and trade unions. At Carina, where there was less participation than at The Gap, heads of households were also the most frequent participators.

Perhaps not surprisingly, more Gap residents had telephones, they were more likely to receive the daily papers and also, more likely to own cars. Ownership of television receivers was about the same at Carina and The Gap.

To sum up, the overall impression - from the data and from general observation - is of two suburbs in marked contrast to one another. The Gap is a middle class suburb occupying a distinct physical space and with a unique suburban identity. It is an attractive, rapidly growing

area, and a large proportion of its population are young adults with young children. Carina is a working class suburb with a fairly stable population, of which the biggest proportion is in the age range of 35-55 years and with children in an older age group than those at The Gap. Set in the suburban sprawl of Brisbane, it is a nondescript kind of place, taking its character from the Housing Commission estate that forms a large part of it.

So much for the general picture of Carina and The Gap. The discussion now turns to the question of the adequacy of the samples of residents selected from the two suburbs.

THE SAMPLES: HOW REPRESENTATIVE?

The final task in this chapter is to match the characteristics of the Survey samples with features of the suburbs from which they were drawn. Table 3.04 shows the sex and age distributions and the religious affiliations of respondents, while the relevant Census data appears earlier in this chapter in Table 3.01.

TABLE 3.04

SEX AND AGE DISTRIBUTIONS AND RELIGIOUS AFFILIATIONS OF RESPONDENTS

		Carina		The Gap	
Sex		Frequency	%	Frequency	%
	Male	191	38	251	42
	Female	299	60	338	57
	No answer	10	2	7	1
Age (percentages)					
	21 - 35 years	(36)	44	(48)	52
	36 - 55	(47)	42	(38)	37
	56 years and over	(18)	14	(14)	9
	No answer		1		2
			(500)		(596)
Religious Affiliation (percentages)					
	Catholic		27		25
	Church of England		33		33
	Presbyterian		11		12
	Methodist		10		11
	No religion		6		7
	Other		12		11
	No answer		1		1
			(500)		(596)

The figures in brackets are the percentages in each age category calculated from 1966 Census data for Carina and The Gap.

It is plain from Table 3.04 that the samples from both suburbs were unrepresentative of the distribution of the sexes at Carina and The Gap; that is, males were underrepresented in both groups. It is important that the reasons for this - which are basically traceable to the financial limitations of the study - be made quite clear. To begin with, it was beyond the resources of the project to make a definitive or an exhaustive study of social class and mental illness in two suburban communities. Rather, the study was conceived as an exploratory one, to isolate the main trends that could be followed in more ambitious, better funded projects. For this reason, and because of the fears of a high refusal rate (discussed in the previous chapter), the prime consideration was to maximize the size of the samples. Therefore interviewers were instructed not to refuse an interview in any house even if the only person at home did not correspond to the category of respondent - in terms of age and sex - needed to balance the interviewer's quota. If the relevant categories of respondent were not available when the interviewer called, an interview was conducted wherever possible rather than have the interviewer make a call-back which, of course, increases the total cost of the survey. And, it must be pointed out, because of the financial

limitations of the project, student interviewers were used instead of employing the services of a survey organization. These student interviewers were interested in doing as many interviews as possible and thus earning as much money as they could. Consequently, some of the interviewing was carried on in the daytime during the week when non-working wives were most often the only persons available. This sex imbalance in the samples is to be regretted. However, there are sufficiently large numbers of males in both groups (191 from Carina and 251 from The Gap) to permit cross-tabulations with adequate numbers in the cells of the matrices for the identification of trends in the data.

The samples fared somewhat better on the distribution of ages and for the respondents' religious affiliations. For the Carina group respondents in the 21-35 years range were, however, rather heavily overrepresented, while the other two groups (36-55 and 56 years and over) were slightly underrepresented. The Gap sample was well matched for the 36-55 years range, slightly overweighted for the 21-35 years group and underrepresentative of respondents in the category 55 years and over. By matching the data on the religious

affiliation of the respondents (Table 3.04) with information presented in Table 3.01, it can be seen that the samples were representative of the religious preferences of the residents of the two suburbs.

Finally, the education and occupational backgrounds of the samples are compared with the relevant characteristics of the suburbs from which they were taken (Table 3.05).

TABLE 3.05

THE SAMPLES: EDUCATION AND OCCUPATIONAL DISTRIBUTION

	Carina	The Gap
Education (percentages)		
Some primary	11	5
Completed primary	25	12
Some secondary	35	36
Completed secondary	8	13
Some university	4	8
Completed university	2	9
Other (technical, trade, etc.)	14	17
	(500)	(596)

Table 3.05 Cont.

	Carina		The Gap	
Occupation*- head of household (percentages)				
Professional	(4)	8	(15)	29
Managerial-Executive	(7)	10	(15)	14
Clerical-Sales	(19)	25	(29)	26
Skilled Manual	(30)	23	(22)	12
Semi-skilled Manual	(17)	6	(6)	5
Unskilled Manual	(22)	21	(9)	10
Other and No answer		8		4
		(500)		(596)

* The occupational classification is based on the scheme suggested by Broom, Jones and Zubryzcki.[9]

Occupation - head of household (percentages)	Total Sample
Professional, Managerial-Executive	31
Clerical - Sales	26
Manual	38
Other, No Answer	5
	(1096)

Looking first at the distribution of the samples by the respondents' education, difficulties of comparison arise because the Census data (reported in Table 3.01) is based on

different categories. It appears however, that the samples from both suburbs - while reflecting the differences between Carina and The Gap - were underrepresentative of persons in the lower educational categories and over-representative of persons in the higher, especially the tertiary educated levels. A similar pattern emerges for the occupations of the heads of households, although once again, the samples mirrored the differences that exist between the two suburbs. In both the Carina and The Gap samples, the high status occupations were overrepresented, with one exception, managerial and executive workers at The Gap who were representative of the distribution of those positions for the suburb as a whole. The trend is reversed among manual workers, who were underrepresented in both samples with the exceptions of the unskilled manual workers at Carina and the semi-skilled and unskilled workers from The Gap, whose proportions corresponded quite well with the figures for the two suburbs. Both samples were reasonably representative of clerical and sales occupations; the Carina sample was somewhat overrepresented, while respondents from The Gap in this category were only slightly underrepresented.

Finally, reference to Table 3.05 shows that the distribution of occupations for the total sample includes

substantial numbers in each of the main groups; 31% were professional and administrative workers, 26% clerical and sales, and 38% manual workers. Given the central purpose of this research, a preliminary study of the relationship between social class and mental illness in the Australian context, this distribution over the total sample will considerably facilitate exploratory analyses and comparisons between the occupational groups.

SUMMARY

Two tasks were accomplished in this chapter. First, there was a description of the social setting of the research project, two suburbs from the Brisbane metropolitan area. Second, aspects of the samples from the Survey of the two suburbs were compared with the characteristics of the suburbs from which they were selected. The next part of this report is an analysis of the research findings and it begins, in the following chapter, with a discussion of the results of the Psychiatric Morbidity Census.

CHAPTER IV

THE RESULTS: PSYCHIATRIC MORBIDITY CENSUS

The central task in this chapter is to present the main findings of the Psychiatric Morbidity Census of Carina, a working class suburb and The Gap, a middle class area.* Through-out the analysis there is a twofold emphasis: on suburban differences, and upon the impact of the patients' socio-economic status on mental illness and seeking psychiatric help. The plan of the chapter is as follows. First there are some introductory remarks and a brief outline of the concepts underpinning the Morbidity Census. Second, there is an analysis of the amount and type of psychiatric illness in the two suburbs, and this is supplemented by some additional data from the questionnaire Survey. Third and finally, the patterns of use of psychiatric treatment facilities are considered.

*The writer wishes to thank Professor F.A. Whitlock for permission to use the data from the Morbidity Census, especially as he has not had an opportunity to work with it. It must be made clear that the analysis and interpretation of the Census data is entirely the work and responsibility of the writer.

INTRODUCTION

The Psychiatric Morbidity Census was an attempt to make a systematic and comprehensive survey of the prevalence of mental illness in two Brisbane suburbs. Essentially, it is concerned with cases of treated mental illness only; that is, with persons who have come to the notice of psychiatric agencies or other community facilities for the treatment of the mentally disturbed. Thus, while the data from the Morbidity Census enables important comparisons to be made, it does not permit estimation of the total amount of mental illness in the two suburbs. For the latter, a different research design with psychiatric interviews or symptom rating scales on a cross-section of the population would be required. However, some information from the door-to-door questionnaire Survey will be discussed in this chapter; specifically, the question about whether anyone from the respondent's household has needed to seek treatment for mental illness.

The concept of prevalence as it is used here should be mentioned briefly. In their study which forms the guidelines for the present work, Hollingshead and Redlich used this definition:

> Prevalence is defined as the number of cases of a specified disease present in a population aggregate during a stated interval of time.[1]

The Psychiatric Census of Carina and The Gap was conducted over a period of one year. This approach to the study of mental illness is based on what Krupinski and his associates call period-prevalence rates of the disorder, and it may be distinguished from the point-prevalence method which indicates the occurrence of the phenomena in the community on a given day.[2] The period-prevalence approach has some distinct advantages: first, it enables a sufficiently large number of cases to be observed to permit statistical manipulation - a particularly important consideration in a study confined to two suburbs; second, it gives a clear picture of both acute and chronic diseases in the population and it overcomes the problem of random variations that might influence data gathered from observations on a single day.

A few remarks are in order before turning to the data. The principal concern here is to 'set the scene' for an examination of the relationship between social class and mental illness, by looking at the cases of mental disorder located in the Psychiatric Census. Within the

limitations of space available, the analysis is essentially a preliminary one designed to isolate the main trends. Tests of significance will not be used: instead, cross-tabulations will be employed, though the small number of cases will narrow the feasibility of these to two and three way cross-tabulations. As this will be the policy through-out the report, in the analysis of the Census and the Survey data, some justification is required. There are two main reasons for relying on 'cross breaks' rather than on statistical tests. In the first place, it is important in the exploratory phase of research not to limit productive lines of inquiry by insisting that the findings prove to be significant. That is, when the task at hand is to explore trends and to generate hypotheses, it is not fruitful to disregard or to omit results because they fail to meet stringent criteria of significance. In the second place, it could be argued that for both the Census where patient populations (not samples) are involved, and the Survey with the quite high non-response rate, tests of significance are inappropriate because the assumption of a strict probability sample - on which such procedures rest - is not met.[3]

THE FINDINGS

First, the general picture; will the prevalence of mental illness be highest in the working class or in the middle class suburb? The data in Table 4.01 tell the story.

TABLE 4.01

PSYCHIATRIC MORBIDITY CENSUS: CARINA AND THE GAP

Suburb	Patients Over 16 years*	Total cases
Carina	192	219
The Gap	90	105
	(282)	(324)

*This group is separated because it is used frequently in the analysis to follow, instead of the total sample.

The differences between the two suburbs were quite dramatic, 219 cases from Carina and 105 from The Gap. Furthermore, these differences were maintained if only those cases over 16 years of age were considered (Carina supplied 192 cases, The Gap 90). The data are impressive; during the period of one year, the Morbidity Census located more than twice as many cases from Carina as were found from The Gap. And, it

should be remembered, the populations of the two suburbs were approximately the same by the 1966 Commonwealth Census figures (by the 1970 Census estimate, The Gap has the largest population). Thus the prevalence rates of mental illness were more than twice as high in the low status suburb as in the high status area. This finding is consonant with previous research reported by other investigators, of areal differences - particularly those reflecting the influence of socio-economic variables - in the rates of mental illness.[4]

So much for the overall view. The immediate question is whether, as Martin[5] puts it, "the behavior and personality patterns ascribed to suburbia are in reality those of class and age" (or some other demographic variable)? Such a question directs attention to the problem of whether it is features of the suburb (as a unique socio-cultural environment) or individual factors (such as socio-economic status, age and the like) which are operating as independent variables on the dependent variable, in this case, mental illness. However, it should not obscure the possibility of an interrelationship between the independent variables of suburb as a 'community' and, say, class status: for example, does the experience of being a manual worker living in a white collar suburb have the same consequences

for mental health as residence in a blue collar area? The preliminary analysis begins, then, with a cross-classification of the patient populations by the various demographic variables; sex, age, civil status and occupation.[6]

Consider first the sex distribution of the cases from both suburbs (the details appear in Table 4.02). Females were overrepresented in the patient groups from both suburbs;

TABLE 4.02

SEX DISTRIBUTION OF CASES FROM THE PSYCHIATRIC MORBIDITY CENSUS

	Carina	The Gap
Male	(84) 38%	(42) 40%
Female	(133) 61%	(62) 59%
No answer	(2) 1%	(1) 1%

they comprised 61% of the cases from Carina and 59% from The Gap. This finding, of course, should not be at all surprising. It is a well documented fact that women are found in disproportionate numbers as patients in mental hospitals and at psychiatric clinics. The usual reason given for this by most observers is the greater willingness

of females to share the burden of their psychological troubles and the cultural injunction on males with problems to 'suffer in silence'.[7]

Details of the age distributions of the patients are to be found in Table 4.03. A couple of points are worth noting. First, there were differences in the age distributions of the two patient populations. For example, a large proportion of the cases from The Gap 54%, were in the age range 26 to 45 years, the figure is 38% for Carina. Similarly, 22% of cases from Carina were under 20 years of age compared to 17% from The Gap. Second, the age distributions of the patient groups do not always reflect the actual distribution of the ages of residents at Carina and The Gap. While 14% of the population of both suburbs is in the age range 36 to 45 years, this category provided nearly twice that proportion of cases in the two patient groups. In like fashion, the age category 66 years and over - into which 4% of the residents in both suburbs fall - was overrepresented in the patient populations, supplying 10% of the Carina cases and 7% from The Gap. The point is, that certain age categories provided disproportionate numbers of patients; the range 26 to 35 years from The Gap, 36 to 45 years from both suburbs, and 66 years and over

from both suburbs, but especially from Carina. Notably, in only one category, patients under 20 years of age, were the cases underrepresentative of the actual distribution of ages in the suburbs. Given the small number of cases involved overall, these figures might not be particularly significant, rather they may represent random variation in a small sample. However, it is argued that the Morbidity Census was a thorough coverage of the available avenues for treatment of mental disorder and that the data reveal important differences between the patient groups.

TABLE 4.03

AGE DISTRIBUTION OF CASES (percentages)

Age	Carina		The Gap	
0-15 years*	(38)	12	(37)	14
16-20	(10)	10	(8)	3
21-25	(6)	7	(5)	7
26-35	(12)	12	(21)	30
36-45	(14)	26	(14)	24
46-55	(10)	13	(8)	10
56-65	(5)	8	(4)	5
66 years and over	(4)	10	(4)	7
No answer		1		1
		(219)		(105)

*These age categories used to analyze the Morbidity data are slightly different from, but still comparable with, the Commonwealth Census age categories which are given in brackets.

The marital status of the patient groups is reported in Table 4.04. These figures require comment because there was a marked difference between the suburbs in the proportion of patients listed as married. First of all, it

TABLE 4.04

MARITAL STATUS (percentages)

Marital Status	Carina	The Gap
Single	23	10
Married	56	78
Widowed	15	2
Divorced, Separated	5	9
No answer	1	1
	(192)	(90)

can be seen that Carina had more than twice as many single patients as The Gap, the figures were 23% and 10% respectively. This reflects, at least in part, the fact that some 10% of the Carina patient group was between the ages of 16 and 20 years, compared with only 3% from The Gap (see Table 4.03). Furthermore, whereas only 2% The Gap cases were listed as widowed, 15% of the Carina group were in this category and it is very likely that many of them were residents of the low-cost, low-rental Housing Commission

estate in that suburb. On the other hand, 9% of the cases from The Gap were described as divorced or separated, compared with 5% from Carina. These last figures are somewhat surprising; it might reasonably be expected that Carina, the Housing Commission suburb, would have the highest proportion of divorced or separated persons, especially the latter, in the patient population - apparently this is not so. Perhaps the high cost of divorce makes it more likely to be found at The Gap. Anyway, future analyses would do well to differentiate between 'divorced' and 'separated' patients.

Finally, but perhaps most important in terms of the aims of the present study, the occupational distribution of the patient groups appears in Table 4.05. A striking

TABLE 4.05

OCCUPATIONAL DISTRIBUTION OF CASES FROM THE PSYCHIATRIC MORBIDITY CENSUS* (percentages)

Occupation	Carina		The Gap	
Professional	(4)	6	(15)	16
Managerial-Executive	(7)	1	(15)	13
Clerical-Sales	(19)	16	(29)	25
Skilled Manual	(30)	14	(22)	21
Semi-skilled Manual	(17)	1	(6)	-
Unskilled Manual	(22)	22	(9)	11
Pensioner-Student	-	22	-	6
Unclassified, Home duties, No answer	-	18	-	8
		(219)		(105)

*The occupational categories listed in this table are based on a condensed form of the occupational classification of the Australian workforce suggested by Broom, Jones and Zubryzcki.[8] The figures in brackets are the percentage of the male workforce in each suburb in the occupational categories; this information appears in Table 3.01 in the previous chapter.

thing about the data in this table is the high proportion of cases falling into the categories "pensioner or student", "homeduties" and "unclassifiable or no answer". Thus some 40% of the Carina patients and 14% from The Gap can not be ranked for socio-economic status by placement in an occupational hierarchy. This hiatus in the data will demand caution in the interpretation of the relation between occupational status and mental illness which follows. Krupinski and Stoller's warning about the inadequacy of occupation by itself - as a measure of the status of psychiatric patients - has considerable force.[9] There is a lesson to be learned here, though some part of the problem at least stems from the circumstances in which the data was gathered: in some instances the pro-forma was completed by psychiatrists and general practitioners who were reluctant to give any information that might reveal their patient's identity, or who did not realize the importance of giving full and specific details of the patient's occupation; on other occasions the information was obtained from general hospital out-patient records, often after only

a brief visit by a patient who had provided minimal details for the case-file. If future prevalence studies based on a census of treated cases are to determine satisfactorily the patient's socio-economic status, they will require more detailed information than that sought in the present project.[10]

Substantial differences exist between the number of cases described as "pensioner or student" in the two suburbs. Six percent of The Gap patients were in this category while the figure was 22% for Carina; on a priori grounds it is reasonable to suspect that this last group comprises mainly pensioners residing in State Housing Commission dwellings. It will be worthwhile, because of the numbers involved overall, to look more closely at these patients in a separate analysis (see Appendix 3).

Turning now to the occupations of The Gap patients, it can be seen that these fairly closely approximate their actual distribution in the suburban population. Blue collar patients made up 32% of the total cases (37% of the male workforce at The Gap are engaged in blue collar work),

clerical and sales workers comprised 25% of the cases (29% of the male workforce) and professionals and managers 29% of the total (30%). Obviously, each of the three major categories was slightly 'underrepresented' - in the sense that the proportion of patients in each group did not exactly reflect their actual distribution in the male workforce of the suburb. This can be attributed, it is suggested, to the fact that 14% of the cases from The Gap were not able to be ranked for socio-economic standing. Had this been possible - and the assumption here is that they would have been spread evenly over the main groups - then it appears that the occupational backgrounds of The Gap patients would mirror the occupational profile of that suburb.

Somewhat more difficulty is posed by the Carina patients from which an even larger slice (40%) was unclassifiable for occupational status. Looking at the data, both professionals and managers and the clerical-sales workers were slightly underrepresentative of the distribution of these positions in the male workforce at Carina. Seven percent of the cases were described as professional or managerial workers (11% of the male workforce in the suburb is engaged in that kind of work) and 16% were clerical and sales workers (19%). Manual workers though, were grossly

underrepresented; indeed only 37% of the total cases were listed as manual workers whereas the 1966 Census figures reveal that 69% of the male workforce at Carina is employed in blue collar jobs. Within the ranks of the Carina blue collar patients the picture is clouded further when it is seen that the proportion of unskilled workers (22%) matches their strength in the suburban workforce. However,skilled and semi-skilled workers were underrepresented: only 1% of the cases were described as semi-skilled workers when, in fact, 17% of the male workforce is so employed,[11] while the figure for skilled workers was 14% (30%). An interesting hypothesis, but one which is untestable from the data available, is that these figures reflect the better mental health of skilled and semi-skilled workers living in a working class environment. Such speculations, however, remain the task of future research projects in Australia, in the field of social class and mental illness.

Two possible interpretations spring to mind of the pattern of occupations of the Carina patients. On the one hand, it may be that the bulk of the patients who can't be ranked for socio-economic status because of the lack of information about them are from blue collar backgrounds.

In that case, the overall distribution of the Carina patients' occupations reflects the occupational structure of the suburb as a whole - with the likelihood that unskilled workers may be slightly overrepresented. On the other hand, if those 'unclassifiable' patients are distributed equally over each of the major groups (professionals and managers, clerical-sales and manual workers) then it will be that the blue collar households at Carina supply a disproportionately low number of psychiatric patients. Given the data at hand it is difficult to know which of these interpretations is correct; to throw some light on the matter it will be necessary to look ahead at the data on the relationship between occupational status and treatment source (to be presented later in this chapter).

For the Carina patients the largest number of cases unclassifiable for occupational status came from two treatment sources, general practitioners and public hospital facilities, and both of these sources tended to be favoured by blue collar patients. This conjunction of circumstances, it is suggested, leads to the tentative conclusion that the majority of 'unclassifieds' among the Carina cases were most likely persons from manual working

backgrounds. Following from this, it can be argued that the distribution of occupations of the Carina patients (like those from The Gap) would closely resemble their distribution in the workforce of that suburb - with the possibility that manual workers might be somewhat over-supplied in the patient group.

In sum, during the Psychiatric Morbidity Census more than twice as many patients were located in the working class suburb than were found in the middle class area. However - and this finding should be viewed with caution because of the limitations of the data - within the suburbs, the prevalence of psychiatric disorder appeared to be unrelated to socio-economic standing as measured by the patient's occupational status. In both suburbs, the distribution of each of the major occupational groups (professionals and managers, clerical-sales and manual workers) in the patient populations appeared to match their composition in the suburban workforce.

Are there socio-economic differences in the type and severity of mental illness among the patient groups? To answer this will require an examination of the relationship between occupational status and psychiatric diagnosis (the

assumption here is that the diagnostic label is an indication of the severity of impairment, for example that schizophrenia is more serious than an anxiety state). First however, it will be helpful to look at the pattern of diagnoses for the two suburbs. Table 4.06 shows that

TABLE 4.06

PSYCHIATRIC DIAGNOSIS: CARINA AND THE GAP (percentages)

Diagnosis	Carina	The Gap
Functional Psychoses:		
Schizophrenia	10	9
Manic-depressive psychosis	9	13
Other functional psychoses	1	2
Organic Psychoses	8	10
Psycho-Neuroses:		
Anxiety state	22	22
Neurotic-depressive reaction	18	13
Other neuroses	10	16
Personality - Character Disorders	8	6
Drug - Alcohol Dependence	10	8
All others (subnormality, unclassiable, no answer)	4	2
	(192)	(90)

there were very few differences between Carina and The Gap. For example, to take two of the commoner forms of psychiatric morbidity; 10% of the Carina group were diagnosed as schizophrenic, the figure was 9% for The Gap, while 22% of the patients from both places were suffering from an anxiety state. Although the diagnostic profiles of the two suburbs were very similar, this should not be allowed to obscure the fact that the actual prevalence rates of the disorders were highest at Carina - for example there were 20 cases of schizophrenia at Carina (10% of the total), compared with 8 cases located at The Gap (9%).

There is an interesting trend here which deserves comment: the pattern of diagnosis of manic-depressive psychosis and neurotic depression in the two suburbs. Nine percent of the Carina cases were labelled as manic-depressive psychosis, compared with 13% from The Gap. On the other hand, 18% of the Carina patients were diagnosed as neurotic depressives while only 13% of The Gap patients were so diagnosed. Could it be that many of these patients presented at treatment agencies with the same condition - some kind of depressive illness - while the end result was that patients from the low status area were more likely to be given the

less serious diagnosis of neurosis (i.e., one with a better prognosis) than patients from the high status area who were more often labelled psychotic? Of course the possibility that the trend observed is the result of random variation due to the unreliability of psychiatric diagnosis, should not be overlooked.

In the light of the well established finding of an inverse relationship between social class and the seriousness of psychiatric diagnosis,[12] these seemingly anomalous figures warrant further examination. To jump ahead again, an inspection of the relation between occupational status and diagnosis (Table 4.07) revealed that at Carina, the same proportion of cases from both white and blue collar backgrounds (11%) were diagnosed as manic-depressive. Further, 15% of the white collar and 23% of the blue collar Carina patients were labelled as neurotic depressive. At The Gap, the proportion of both manic-depressive psychosis and neurotic depression was highest among patients from white collar homes. Despite the obviously small numbers of cases involved, it looks like the trend observed in Table 4.06 simply reflects the high proportion of blue collar patients from Carina who have been diagnosed as neurotic depressives.

In other words, patients from the low status area with a depressive disorder were not more likely to receive a less serious diagnosis than patients from the high status suburb with a similar depressive illness.

To return to the main theme, the relationship between occupational status and diagnosis is presented in Table 4.07. The data show that patients from white and blue collar home backgrounds had remarkably similar patterns of psychiatric morbidity, and this trend held good for both suburbs.

Several points require brief mention; the first of these is a general caveat in view of the limitations of the information on the patients' occupational status and the small number of cases used in the present analysis. Looking at the data, there was a slight trend for patients from white collar households to have the highest rates of neurosis. And, the proportion of psychoses was highest among patients from blue collar homes, but the differences between blue and white collar patients from both Carina and The Gap were quite small - no more than 2%. Turning to

TABLE 4.07

OCCUPATIONAL STATUS AND PSYCHIATRIC DIAGNOSIS:

CARINA AND THE GAP (percentages)

Diagnosis	Carina		The Gap	
	White* collar	Blue** collar	White* collar	Blue ** collar
Psychoses:				
Schizophrenia	13	12	10	4
Manic-depressive psychosis	11 (26)	11 (28)	12 (30)	8 (31)
Other functional psychoses	0	1	0	4
Organic psychoses	2	4	8	15
Psycho-Neuroses:				
Anxiety state	26	18	22	19
Neurotic-depressive reaction	15 (54)	23 (50)	16 (56)	12 (43)
Other neuroses	13	9	18	12
Personality-Character Disorders	9	10	4	15
Drug-Alcohol Dependence	11	12	12	8
All others (subnormality, unclassifiable, no answer)	0	0	0	4
	(46)	(74)	(51)	(26)

* The white collar category comprises patients from professional, managerial, clerical and sales home backgrounds.[13]

** The blue collar group comprises patients from skilled, semi-skilled and unskilled manual working backgrounds.

suburban differences, the blue collar patients from The Gap were the only group in any way 'deviant', with the highest percentage of patients diagnosed as suffering from a personality or character disorder and by far the smallest proportion of cases classified as neurotic. Overall though, the data reveal that there was little or no relationship between socio-economic status and the type and severity of mental illness. If this finding is coupled with the earlier - admittedly tentative - observation made in this chapter, that the prevalence of psychological disorders was unrelated to socio-economic standing, an interesting picture emerges. It is a picture that doesn't match the well established findings of a large number of empirical studies - most of which however, have been carried out in the U.S.A.:

> Such studies have demonstrated that stratification and rates of mental illness are correlated: in general, the higher the socioeconomic position of the individual, the lower the rate of illness.[14]

The point is an important one: in the first place it highlights the paucity of local work on the topic and the urgent need for research in an Australian context; second, it draws attention to the perils of assuming that the findings of empirical social research in one modern

urban industrial society - the U.S.A. - will hold good in the Australian situation. The Psychiatric Census has turned up areal differences in the prevalence of psychiatric disturbance in one high status and one low status suburb, yet the amount and type of illness appears to be unrelated to the patient's socio-economic position. Is the pattern observed a spurious one, attributable perhaps to methodological limitations (due to the small number of cases or to the proportion of cases not classifiable for socio-economic status)? Most likely it is not. While recognizing these flaws, it is argued that the Morbidity Census was a systematic and comprehensive enumeration of the treated psychiatric populations of the two suburbs. The analysis of the Census data has proceeded about as far as it can go; however, additional information which will throw more light on the subject is available from the questionnaire Survey of Carina and The Gap. It is to a consideration of this that the discussion now turns.

> Respondents were asked, in the course of the interview;
>
> Has any member of this household ever needed to seek medical help for a mental or nervous illness?

The answers to this question are particularly instructive because they highlight substantial differences,

in the expected direction (although not of the same magnitude as revealed by the Census data), between the suburbs. Twenty-one percent of Carina respondents said that someone from their household had needed to seek medical treatment for a mental or nervous illness, for The Gap the figure was 15% (not reported in tabular form).

The crucial question is: are there socio-economic differences in the frequency with which householders from Carina and The Gap require help for mental or nervous illness? To find this out it will be necessary to cross-tabulate respondent's replies to the question on psychiatric help-seeking by the occupational level of the head of the household (see Table 4.08 for details).

TABLE 4.08

PSYCHIATRIC HELP-SEEKING BY OCCUPATION OF THE HEAD OF HOUSEHOLD (percentages)

Householder has sought treatment for mental or nervous illness	Carina			The Gap		
	P-M*	C-S	M	P-M	C-S	M
Yes	20	22	22	16	15	11
No	80	77	77	83	85	88
	(86)	(124)	(252)	(256)	(157)	(162)

*P-M= Professionals and managers; C-S = Clerical and sales workers; M = manual workers.

It seems that socio-economic status was not associated with the frequency with which householders from Carina and The Gap sought treatment for psychiatric problems; in other words, the suburban differences were maintained quite strongly. From Table 4.08 it can be seen that among Carina respondents, those from clerical-sales and blue collar home backgrounds were slightly more likely than the professionals and managers to come from households in which someone has required treatment, but the differences were small (2%). At The Gap, respondents across all occupational categories were considerably less likely than their Carina counterparts to report that a member of their family has needed psychiatric help. The figures were 11% for respondents from blue collar homes - and this was the lowest proportion of any occupational group, in either suburb - somewhat lower than respondents from professional and managerial (16%) or clerical and sales (15%) backgrounds.

When the cross-tabulation was run again using the respondent's level of education as the independent variable, a similar result was obtained. Fewer tertiary educated respondents from both Carina and The Gap reported that

members of their household had needed to seek psychiatric treatment, but overall, the suburban differences were paramount (Table 4.09).

TABLE 4.09

PSYCHIATRIC HELP-SEEKING BY RESPONDENT'S LEVEL OF EDUCATION (percentages)

Householder has sought treatment for mental or nervous illness	Carina			The Gap		
	Primary	Second-ary	Tertiary	Primary	Second-ary	Tertiary
Yes	21	22	17	18	14	14
No	78	77	80	82	84	85
	(180)	(214)	(30)	(102)	(292)	(103)

All in all, the pattern which comes into view more clearly now shows that the prevalence rate of mental disorder was twice as high in the low status suburb as in the high status suburb. Yet despite these areal differences, the amount and type of illness seemed to be unrelated to the patient's socio-economic standing. Certainly the analysis of both the morbidity data and the replies to the questionnaire item on psychiatric help-seeking points in this direction. It would be unwise, obviously, to attempt to generalize beyond the scope of this modest study of two

Brisbane suburbs to the context of the wider Australian community. However to be sure, the present study has highlighted some interesting trends - on the one hand, the lack of influence of the patient's socio-economic status on the amount and type of mental illness and, on the other, the primacy of areal differences. But this would not be a novel situation, for it has long been recognized "that both the total amount and the types of deviant behaviour exhibited by residents of various districts differs considerably."[15] For example, Leighton and her colleagues observed a somewhat similar phenomenon in their Stirling County (rural Nova Scotia) study, when they found that a person's mental well-being was affected (not only by his own class position but) by the class level of his surrounding community. The Leighton study made much of a distinction between 'well-integrated' communities, and what they called 'depressed areas.'[16] Closer to home, a similar point was made by Melbourne epidemiologist Alan Stoller when he urged that special notice should be taken of the characteristics of particular areas, such as the proportion of younger and older persons, changing patterns of housing, the numbers of transients, the problems of social isolates and such trends as areal variations in wife desertion, divorce, crime, delinquency and vandalism.[17]

For the present study, it is well worth considering the possibility that Carina - the Housing Commission area with low-cost dwellings - may be the collecting place for mentally disturbed persons (and perhaps other deviants too). Of course there may be other factors operating than simply low-cost housing attracting pathology prone individuals to Carina, and this point has been made by Dunham (and others) as the 'drift hypothesis' with respect to schizophrenics and certain social areas;

> ...the schizophrenic reaction was of the type that prevented a meaningful relationship with family and peer group members and so the person withdrew from these relationships and selected an environment where he would more likely be left alone and so did not have to become involved in close interpersonal relationships.[18]

As well, Yinger has argued that it is a good idea to consider rate differences in mental illness beside the levels of other social pathologies in any given community - a piece of advice that will certainly be followed in a later stage of the Carina - The Gap project.[19] 'The same' personal tendencies, Yinger believes, are associated with different patterns of behaviour depending on the social and cultural context and he quotes Clausen to support this contention -

> (In our urban slums) there are many young people with severe problems of adjustment and there are social forms which predispose many adolescents to seek "kicks" or escapes. Some of these persons become habitual delinquents, some experiment with drugs, and some develop neurotic defences and psychotic states.[20]

In short, what is implied here - though it is beyond the means of the present analysis - is a comparative examination of Carina and The Gap to determine the range of situations that facilitate or restrain disturbed persons with respect to a variety of possible deviant behaviours.

Does a suburb like Carina attract more psychiatrically disturbed persons than a predominantly middle class area such as The Gap? Are there more 'outlets' or opportunities for all kinds of deviance at Carina? Or is Carina, for a variety of reasons, simply a more stressful place in which to live than The Gap? These questions are unfortunately beyond the scope of this report. However, it looks as though ecological aspects must be considered to understand the prevalence rate differences between Carina and The Gap, although it is not clear what these are from the available data.

Two final points need to be made about the analysis of the prevalence figures. The first one is a cautionary note: within the limitations of space available (as was stated), it has not been possible in this exploratory investigation to make an exhaustive coverage and evaluation of all the factors which may be operating to produce the areal differences between Carina and The Gap. Rather, the analysis has focussed on the variable which the extensive literature on the topic suggests has most promise - socio-economic status. Second, it should be recognized that the 'nominal' index of social class (occupational status) used here might be inadequate. Certainly occupational rank or level of education may be readily transformed into the 'language of the variable', for the analysis of empirical social survey data. Yet it may be necessary - indeed it will probably be essential - for sociologists working in the field of mental health research to go beyond those easily quantifiable indices of socio-economic status, to behavioural measures of social class such as style of life, job satisfaction, consumption patterns and the like.

All that remains to be done in this chapter is to look at the patterns of use of psychiatric facilities by patients from Carina and The Gap. Table 4.10 shows where the patients were being treated when they were located by the Morbidity Census.

TABLE 4.10

TREATMENT AGENCIES USED BY PATIENTS FROM CARINA AND THE GAP (percentages)

Treatment Agency	Carina	The Gap
Private Psychiatrist	7	22
General Practitioner	22	29
Lowson House*	22	24
General Public Hospitals**	30	2
Psychiatric Public Hospitals***	7	8
Psychiatric Clinic (O-P)	6	7
Alcoholic Clinic	1	2
Repatriation Hospitals	4	4
No information	1	3
	(192)	(90)

* An acute, in-patient psychiatric annex at the Royal Brisbane Hospital (northside) which serves all of Brisbane.

** All out-patient and in-patient cases - excluding Lowson House cases - for all hospitals. For Carina, the Mater and Princess Alexandra; for The Gap, Royal Brisbane Hospital.

***Wolston Park Hospital and Chermside Neuro-psychiatric Hospital.

The data reveal impressive differences between the suburbs, particularly with respect to the numbers of cases found in treatment with a private psychiatrist and at general public hospitals. Twenty-two percent of The Gap patients were located while receiving private psychiatric care, the figure is only 7% of the Carina cases. The trend was reversed for treatment at general public hospitals, at which 30% of the Carina patients were found compared with 2% from The Gap. Suburban differences were less pronounced for the proportion of cases treated by general practitioners; about a third of The Gap were being treated by a doctor in their suburb, compared with a somewhat smaller group from Carina (22%). For the other treatment agencies the patterns of use are quite similar in Carina and The Gap: this includes a sizeable proportion of patients (22% and 24% respectively) located at Lowson House - the acute, in-patient annex of the Royal Brisbane Hospital, which serves the whole city.

How are the data to be explained? One possibility is that there may be differences in the availability of psychiatric treatment for residents of these two suburbs. This factor may explain, in part at least, the greater use made by Carina patients of general public hospital services:

Carina, on the southside of the city, is served by two general public hospitals while on the northside, The Gap has only one. But this is really the only major difference between the suburbs. They are located about equidistant from the city centre where private psychiatric facilities exist, and both are served equally well by general medical practitioners, the only source of psychiatric treatment within either suburb. In fact, systematic enquiries revealed that there are no mental health facilities - save pastoral counselling by some churches - at Carina and The Gap.

Are there patterned differences, then, in the use of psychiatric treatment resources by patients from white and blue collar home backgrounds? Certainly the extensive literature on sociological factors in the treatment of psychological disorders indicates that this will be a fruitful line of enquiry[21] (see Table 4.11 for details).

TABLE 4.11

OCCUPATIONAL STATUS AND TREATMENT AGENCIES USED BY PATIENTS FROM CARINA AND THE GAP (percentages)

Treatment Agency	Carina		The Gap	
	White collar	Blue collar	White collar	Blue collar
Private Psychiatrist	15	5	22	19
General Practitioner	13	14	35	23
Lowson House	24	34	24	23
General Public Hospitals	19	33	2	-
Psychiatric Public Hospitals	13	1	4	12
Psychiatric Clinic	7	7	8	4
Alcoholic Clinic	2	1	4	-
Repatriation Hospitals	7	3	2	8
No information	-	1	-	12
	(46)	(74)	(51)	(26)

The situation depicted in Table 4.11 is quite complex because it involves the interplay of the influences of suburb and the patients socio-economic status. As well, the analysis is hampered by the recurrent difficulty of the small number of cases. To simplify matters, it will be helpful to focus on the five treatment sources which account

for most of the cases: private psychiatrists, general practitioners, Lowson House, general public hospitals and psychiatric public hospitals.

Looking first at the use of private psychiatrists it is clear that at Carina, consulting a private psychiatrist was confined very much to the white collar patients; 15% of them, compared with only 5% of blue collar patients were located in private psychiatric care. Nor should this finding be surprising, it is the pattern of social class and psychiatric treatment frequently reported in the literature.[23] The proportion of patients in private therapy was considerably higher at The Gap - across both occupational groups. There, interestingly enough, nearly as many patients from blue collar backgrounds (19%) as from white collar homes (22%) were consulting private psychiatrists. This is a rather curious finding: on the one hand, it may be that manual workers in the high status suburb adopt the patterns of seeking psychiatric help characteristic of the white collar class; on the other hand, the trend might be due simply to random fluctuations because of the small number of blue collar cases at The Gap. Unfortunately the data available

preclude a firm interpretation, however they do highlight a trend which will warrant further investigation in the future.

Among Carina patients, there were no socio-economic differences in the use of general practitioners which accounted for 13% of white collar and 14% of blue collar patients. The Gap patients - particularly those from white collar homes - were much more likely to take advantage of the services of a local general practitioner. Thirty-five percent of white collar and 23% of blue collar patients from The Gap were located at general practitioners. Because of the paucity of information about the role of general practitioners in the treatment of psychological disorders, it is difficult to assess the significance of these figures. For example: lacking as they do any adequate specialized psychiatric training, are they able to identify and treat correctly the patient's presenting illness? What part do they play in referring patients to other, perhaps more appropriate forms of psychiatric care?[24] One thing is clear from this study. With the large volume of cases handled by general practitioners - nearly a third of all patients from The Gap (35% of white collar patients in that suburb) - they occupy a central, though little understood place in the treatment of psychiatric disturbance within the community. Urgent

research is needed here in Australia to clarify their role in the mental health field.

The patterns of use of the services at Lowson House (the acute, in-patient psychiatric annex of the Royal Brisbane Hospital) and general public hospitals may be considered together. Two-thirds of the blue collar patients from Carina were located there; 34% at Lowson House and 33% at the two southside general public hospitals. Blue collar patients from The Gap were unlike their Carina counterparts: none were found at the general hospital facilities, while 23% of them were located at Lowson House (as were similar proportions of white collar patients from both suburbs). Nineteen percent of the white collar patients from Carina came from the general public hospitals on the southside.

Finally, there are the patterns of use of the two public psychiatric hospitals (Wolston Park and Chermside Neuro-Psychiatric Hospital). It is amply documented in the literature that the patient populations of large psychiatric hospitals have disproportionately high numbers of low income people.[25] Thus it was not surprising to find socio-economic

differences in the expected direction for The Gap patients: twelve percent of blue collar patients and only 4% of white collar patients were located at these services. The trend was reversed for Carina however; the figures were 13% of white collar patients and a mere 1% of the blue collar cases. But it would be unwise to set too much store by this last finding which may be quite misleading, due perhaps, to the few cases involved.

To sum up, the data on the differential use of psychiatric facilities are suggestive rather than definitive. The methodological limitations of the Morbidity Census - the small number of cases and the fact that it was confined to two suburbs - have meant that it was impossible to determine conclusively the pattern of influence of suburb and the patient's socio-economic status on psychiatric help-seeking. Hopefully, though, the analysis presented here will at once stimulate further research and indicate the most fruitful avenues along which it may be pursued. To that end, the trends observed in the use of private psychiatric help, general practitioners and public hospital services (general and psychiatric) should provide the guidelines for some fertile studies, in an Australian context, of the relationship between social class and psychiatric treatment. In addition,

the data have raised some issues that will be taken up in later chapters; for example, do residents of Carina and The Gap have a clear idea of where to go for psychiatric help and, are there socio-economic differences in knowledge about psychiatric care?

CONCLUDING REMARKS

This chapter has been concerned with an analysis of the Psychiatric Morbidity Census data, focussing on the amount, type and severity of psychiatric impairment, and the patterns of use of treatment facilities. It has been both a comparative study of two suburbs (one a high status area and the other a low status area) and an attempt to determine the influence of the patient's socio-economic status on the behaviours under investigation. Now it is time to turn to some crucial matters in the sociology of mental illness; attitudes to, and the recognition of mental disorders by members of the community. For, as Hollingshead and Redlich (and many others subsequently) have pointed out, mental illness is a socio-cultural phenomenon as well as a psychological one:

> ...abnormal acts can be evaluated only in terms of their cultural and psychosocial contexts... the perception and "appraisal" by other persons of an individual's abnormal behavior as psychiatrically disturbed is crucial to the determination of whether a given individual is to become a psychiatric patient or to be handled in some other way.[26]

Do respondents in the samples from the two suburbs perceive the seriousness of various symptomatic behaviours in the form of brief psychiatric case-histories? Are they able to recognize these behaviours as indications of mental aberration, and therefore, as requiring treatment? These questions are taken up in the next chapter which looks at some results of the questionnaire Survey of Carina and The Gap.

CHAPTER V

PERCEPTION AND RECOGNITION OF MENTAL ILLNESS

INTRODUCTION

This chapter is about the evaluation of the seriousness of psychiatric symptoms and the recognition of mental disorder in simulated case-histories. The data are derived from interviews with samples of respondents from the two suburban areas, Carina and The Gap. The discussion begins with an overall appraisal of the perception of the seriousness of the cases and the level of recognition of psychiatric illness by sample members. Some important implications of the levels of evaluation and recognition by the samples are discussed next. This is followed by an attempt to devise uni-dimensional measures or scales of the evaluation of seriousness and the identification of mental illness. The remainder of the chapter is devoted to an examination of the influence of various personal and demographic factors - notably socio-economic status - upon the levels of evaluation of seriousness and recognition of mental disorder.

THE EVALUATION OF SERIOUSNESS OF PSYCHIATRIC SYMPTOMS

Respondents were presented with eight simulated case-histories of mental disturbance, representing what is regarded in the psychiatric literature as the symptoms of obsessional neurosis, paranoid schizophrenia, drug dependence, senile dementia, simple schizophrenia, endogenous depression, anxiety neurosis and alcoholism.[1] After each case the following fixed-alternative questions were asked:

(a) How serious do you think this is?

(b) Do you think Mr. A (etc.) could be helped by any one of these (from a list of possible help sources) or don't you think he needs any help at all?

(c) Would you say Mr. A has some kind of mental illness or not?

(d) (If 'yes' or 'possibly' to the last question); Do you think this illness can be cured?

First of all, how seriously did respondents from Carina and The Gap perceive the various behaviours depicted in the vignettes? The data appear in Table 5.01.

TABLE 5.01

EVALUATION OF THE SERIOUSNESS OF EIGHT CASE-HISTORIES:

CARINA AND THE GAP (percentages)*

Case	Carina (N=500) Seriousness				The Gap (N=596) Seriousness			
	Very	Quite	Not Very	Not at all	Very	Quite	Not very	Not at all
Obsessional Neurosis	12	42	31	9	16	46	28	6
Paranoid Schizophrenic	40	47	9	1	39	51	8	2
Drug Dependence	23	49	22	3	23	45	25	5
Senile Dementia	10	34	40	16	7	27	45	20
Simple Schizphrenia	16	38	36	7	17	37	35	10
Endogenous Depression	7	34	49	9	7	37	46	9
Anxiety Neurosis	5	28	52	12	3	32	51	13
Alcoholism	55	37	5	1	56	40	3	0

*Don't Know and No Answer categories omitted.

The trends are interesting: in the first place, there was considerable uniformity in the patterns of response by the samples from the two suburbs. Second, and most important, the overall perception of the seriousness of the behaviour in

the case-studies was very low. In only one case did more than 50% of those interviewed judge the behaviour in question to be "very serious"; on the other hand, three of the cases were seen as "not very" or "not at all serious" by over half of the respondents in each instance. Thus respondents generally failed to perceive the psychiatrically aberrant behaviour manifested in the cases as being serious, and this trend held across both suburbs. Looking more closely at the types of illness, only two cases, the alcoholic and the paranoid schizophrenic, were recognized as "very serious" by a substantial proportion of respondents. It is quite likely that the overtones of physical violence in the case of the paranoid schizophrenic and the disruption of occupational and familial roles in the alcoholic case-history caught the attention of respondents. The drug dependence case and, to a lesser extent, the obsessional neurosis were also seen as serious problems. Two important forms of psychiatric pathology - the endogenous depression and the simple schizophrenic - were generally not felt by respondents to be serious.

A relevant question is; to what extent do these findings match the results of other investigations? The only equivalent data are from a recent study of American

college students, using the same graduated response format ("very serious", "quite serious" etc.) but only two comparable case descriptions: 39% of this sample rated the paranoid schizophrenic as "very serious" (the figures for the present study were 40% from Carina and 39% from The Gap) and 20% judged the simple schizophrenic to be "very serious" (Carina, 16% and The Gap, 17%).[2] There are obvious limitations in this comparison, however it is helpful to see the pattern of response of the Carina-The Gap samples in the context of the results of previous overseas research.

THE RECOGNITION OF MENTAL ILLNESS

Do respondents from Carina and The Gap recognize the various symptomatic behaviours in the case-abstracts as mental illness? The data are presented in Table 5.02 and once again an interesting picture emerges. This time though, there were substantial differences between the suburbs. The level of recognition of mental illness was highest at Carina, the predominantly blue collar area. Three case-abstracts (the drug dependence, senile dementia and endogenous depression) were most often recognized as mental disturbance

TABLE 5.02

RECOGNITION OF MENTAL ILLNESS IN EIGHT CASE-HISTORIES: CARINA AND THE GAP (percentages)*

Case	Carina (N=500) Mental Illness or Not			The Gap (N=596) Mental Illness or Not		
	Yes	Possibly	No	Yes	Possibly	No
Obsessional Neurosis	38	23	35	46	25	26
Paranoid Schizophrenic	73	14	13	73	13	13
Drug Dependence	22	13	62	16	14	68
Senile Dementia	17	7	74	13	8	79
Simple Schizophrenic	31	14	53	29	13	56
Endogenous Depression	19	11	67	12	10	77
Anxiety Neurosis	19	10	68	18	10	70
Alcoholism	37	14	45	38	12	47

* Don't Know and No Answer categories omitted.

by respondents from that suburb, whereas respondents from The Gap were most likely to identify mental illness in only one case - the obsessional neurosis. Two cases, the paranoid schizophrenic and the alcoholic - the ones that respondents

from both suburbs most often felt to be "very serious" (see Table 5.01) - were identified as mental illness by the same proportions of the samples from Carina and The Gap in each instance. There was a similar pattern of recognition in both suburbs for two other cases, the simple schizophrenic and the anxiety neurosis.

Overall however, the level of recognition of mental illness in the simulated case-histories was very low, at both Carina and The Gap. Only one case, the paranoid schizophrenic, was identified as being mentally ill by a majority of respondents - 73% in each suburb. Five of the cases were thought not to be mental illness by over half of the Carina-The Gap sample members; three of them (endogenous depression, senile dementia and anxiety neurosis) were seen as mental abnormality by less than 20% of the persons interviewed.

Comparative data are available. Seventy-three percent of respondents from both areas saw the paranoid schizophrenic as mentally ill. This figure is slightly lower than that reported in a Melbourne study conducted in 1968 (78%).[3]

Recognition of mental illness in the Melbourne study was 31% for the simple schizophrenic (31% from Carina and 29% at The Gap) and 33% for the alcoholic (37% and 38%).[4] It is noteworthy that the level of identification of mental illness in these three case-abstracts, in both Australian studies (Melbourne and Carina-The Gap), was far lower than that reported by most American investigators.[5] Finally, whereas only 4% of the Melbourne sample described the anxiety neurotic as mentally ill, 19% of the Carina respondents and 18% from The Gap made that judgement, though it is not at all clear why this should be so.

To sum up, responses to the eight case vignettes revealed, generally, a low level of recognition of their seriousness and a corresponding failure to identify the cases as mental illness. In both the high status and the low status suburb, the trend was for respondents not to perceive the seriousness of the behaviours depicted in the cases, and for an infrequent use of the label of mental illness by the sample members. This point is well illustrated by replies to the question about the appropriate type of help to be enlisted for each case: few respondents recognized

that the behaviours in the vignettes warranted psychiatric treatment. Social workers, close relatives or family friends and local or family doctors were very often suggested as the person to give help. In fact, in only one case (the paranoid schizophrenic) did the bulk of the samples from Carina and The Gap recommend psychiatric intervention. For another case which described the person as having "lost his faith" as one of the symptoms (the endogenous depression), over 60% of the respondents from each area thought the appropriate person to give help was a clergyman (the data on the sources of referral for help are not reported in tabular form[6]).

There are some important points to be made about the data just presented. In the first place, the case-abstracts were illustrative of deviations from both psychiatric and social norms, ranging from socially disruptive behaviour (the violent manifestations of the paranoid schizophrenic) to the bizarre (the withdrawn behaviour of the simple schizophrenic). Yet respondents rarely judged them to be very serious or saw them as indications of mental abnormality. This has important implications for the mental health movement which rests on the assumption that people will, when they

perceive abnormality in their own or other's behaviour, obtain or recommend psychiatric treatment - the earlier the better. Thus in both self and other defined illness - to use David Mechanic's terms[7] - the decision to use psychiatric help is based on the perception that 'something is wrong' and the recognition that it is a psychiatric disorder. Clearly the responses of the Carina-The Gap samples to simulated cases of mental illness indicates a disturbingly low level of 'psychiatric sophistication': respondents will be unlikely to recognize the symptoms and signs of mental disorder in themselves or others and, consequently, they will be unlikely to utilize mental health services in the treatment of such illnesses. Further, the data suggest that this problem will be particularly acute with respect to the so-called 'minor emotional disturbances' (for example, obsessional neurosis and anxiety neurosis) which, although not as incapacitating as the psychoses, still cause widespread disability and misery.[8] Another interpretation of the data is possible however. It may well be that tolerance of 'abnormal' acts - rather than ignorance of psychiatric matters - was guiding the respondents in their judgements of the cases. In other words, the reason that sample members did not view the behaviour in the cases seriously or identify it as mental

illness may be because they were prepared to tolerate a wide range of behaviour in others before they became disturbed about it. The important thing though, is that whether respondents were basically uninformed about mental illness or whether they were simply tolerant of a range of deviant behaviour, the consequences will be the same for the treatment of psychiatric disorder: individuals will be unlikely to seek treatment for themselves or to refer others to psychiatric facilities when the need arises.

In the second place, failure to use psychiatric treatment resources may have serious consequences and here, two of the cases require brief mention. One is the endogenous depression, for, as Jordan, Earnshaw and Harper point out; "the suicide risk known to be associated with severe endogenous depression makes early referral imperative."[9] The other is the case of the person suffering from senile dementia and in this context it is worth quoting Jordan, Earnshaw and Harper again:

> The need for diagnosis, the possibility of treatment and the importance of mobilizing community resources in respect of behavioural disorders in the elderly should be more widely appreciated.[10]

Third, the data do not provide an explanation of the gross differences in the prevalence of mental illness at Carina and The Gap (reported in Chapter 4). Replies to the fictitious case-histories revealed no differences between the suburbs in the evaluation of the seriousness of the cases, while areal variations in the recognition of mental illness did not indicate any pattern that would shed light on the prevalence figures - save the fact that Carina residents were somewhat more likely to identify some particular forms of psychiatric abnormality and thus to be somewhat more likely to present for psychiatric treatment.

That is the broad picture; but what does it mean in terms of a person's general level of evaluation and recognition of mental disorder? Does it mean that responses have been made by the Carina-The Gap samples in a somewhat random way. Or, does it mean there is some consistency in the responses over the eight cases so that it is possible, for instance, to speak of a generalized pattern of recognition of mental illness? If there is consistency in the response

pattern, it would be expected that those who had indicated recognition of mental illness on one item would be more likely to do so on any other item than someone who failed to identify it on the first item. That is, the 'identifiers' on one item would be more likely than the 'non-identifiers' on that item to give recognition of mental illness responses to the other case-abstracts.

Unless one can demonstrate this consistency in response, then it cannot be asserted with much confidence that the items form a unitary scale of the recognition of mental illness. To this end, item homogeneity was tested by calculating item-total correlations for each item with the total score over all items; this provides a measure of the extent to which individuals who respond 'positively' (in the recognition direction) to one item, respond similarly to all other items.[11] In fact, this procedure was followed for the eight evaluation and the eight recognition items, and the steps involved in the construction of the two scales will be discussed in some detail here.

To begin with the evaluation items - whether respondents saw each case as "very serious", "quite serious", etc. - the index was formed over the eight items. The scoring procedure, built into the correlational analysis, was as follows: each item was dichotomized at or as near to the median as possible; 'positive' responses, emphasizing the seriousness of the behaviour depicted in the case, were given a score of 0, 'negative' responses, indicating that the respondent didn't perceive the case as serious, were scored 1.[12] The items and the item-total correlations appear in Table 5.03.

TABLE 5.03

ITEM-TOTAL CORRELATIONS:

EIGHT EVALUATION ITEMS (N=1,096)

Item Number	Case	Item-total Correlations
1	Obsessional Neurosis	0.25
2	Paranoid Schizophrenic	0.40
3	Drug Dependence	0.31
4	Senile Dementia	0.25
5	Simple Schizophrenic	0.36
6	Endogenous Depression	0.37
7	Anxiety Neurosis	0.43
8	Alcoholic	0.33

The item which best predicts total score is item 7 (the simulated case of anxiety neurosis), while items 2 (paranoid schizophrenic), 5 (simple schizophrenic) and 6 (endogenous depression) also have quite high coefficients. All of the items, however, have correlation coefficients which are significantly different from zero at better than the 0.01 level of confidence. It is reasonable to conclude that respondents were answering the set of items in a patterned and systematic fashion. In other words, the items form statistically quite a reliable measure of the evaluation of the seriousness of mental illness. Respondents could score from zero to 8 on the index: a 0 is a 'high' score indicating the respondent gave 'positive' responses to all eight items - he perceived all of the cases as serious; an 8 is a 'low' score, obtained by those respondents who felt that none of the cases were serious. The distribution over the index is presented in Table 5.04.

TABLE 5.04

DISTRIBUTION OF SCORES ON THE INDEX OF THE EVALUATION OF THE SERIOUSNESS OF MENTAL ILLNESS (N=1,096)

Score	Frequency	Percent
0	26	2
1	87	8
2	127	12
3	190	17
4	219	20
5	207	19
6	135	12
7	84	8
8	21	2

It is clear that the distribution of scores approximates a 'normal curve' - respondents are spread over the scale. The bulk of them (56%) fall into the middle categories (3,4,5), while approximately equal numbers of respondents are in the first three categories (22%, the 'high' scores) and the last three (the 'low' scorers, 22%). The index has been collapsed into three groups (high, medium and low) for the purposes of convenience in analysis.[13]

The recognition of mental illness scale was formed in essentially the same way. Once again the eight items were used and the scoring procedure was that employed in the calculation of the item-total correlations. Each item was dichotomized at or as near as possible to the median. 'Positive' responses, identifying the behaviour in the case-abstract as mental illness, were scored 0, 'negative' responses were given a score of 1. Table 5.05 shows the items and the item-total correlations. This time the correlation coefficients for each item with total score

TABLE 5.05

ITEM-TOTAL CORRELATIONS: EIGHT RECOGNITION ITEMS (N=1,096)

Item Number	Case	Item-total Correlations
1	Obsessional Neurosis	0.20
2	Paranoid Schizophrenic	0.28
3	Drug Dependence	0.48
4	Senile Dementia	0.37
5	Simple Schizophrenic	0.46
6	Endogenous Depression	0.49
7	Anxiety Neurosis	0.52
8	Alcoholic	0.34

are higher. Item 7 (anxiety neurosis) is the one which best predicts total score and items 3 (drug dependence), 5 (simple schizophrenic) and 6 (endogenous depression) also have quite high correlations. However, even the two lowest items, 1 (0.20) and 2 (0.28), have correlation coefficients which are significantly different from zero at greater than the 0.01 level of confidence. There is then, fairly clear evidence that a single dimension - recognition of mental illness - runs through this set of items and that respondents were answering them in a consistent manner. That is to say, the items form quite a reliable measure of the identification of mental disorder.

Respondents could score from zero to 8 on this index. A 0 is a 'high' score meaning that the respondent gave 'positive' (identification) responses to all eight items, while an 8 is a 'low' score given to respondents who identified none of the case-histories as examples of mental illness. The distribution of scores over the index is to be found in Table 5.06.

TABLE 5.06

DISTRIBUTION OF SCORES ON THE INDEX OF RECOGNITION OF MENTAL ILLNESS (N=1,096)

Score	Frequency	Percent
0	23	2
1	51	5
2	95	9
3	124	11
4	179	16
5	211	19
6	222	20
7	146	13
8	45	4

It can be seen that the distribution of scores is somewhat skewed towards the 'low recognition' end of the scale. For convenience in the analysis to follow, the index has been collapsed into three groups; 'high' (0,1,2),'medium' (3,4,5,6) and 'low' scorers (7 and 8).[14]

Before considering the effects of such factors as age, sex and socio-economic status on scores on the two scales, it will be useful to look briefly at an 'indirect test' of the adequacy of these measures. If these scales measure

what they purport to, then it would be expected, on a priori grounds, that there would be patterned differences with respect to the amount of contact the respondent had with mental illness.

During the course of the interview all sample members were asked;

> Has any member of this household ever needed to seek help for a mental or nervous illness?

The relationship between contact with mental illness and scores on the index of evaluation of the seriousness of mental illness and the index of recognition of mental illness, is presented in Table 5.07. The trend is clear; experience with mental illness is related to scores on both scales. At Carina and The Gap, respondents from households in which a member has needed to seek help for a mental or nervous disorder were most likely to be high scorers on the index of evaluation of seriousness and the recognition of mental illness index. That is, experience with mental illness increases the probability of the respondent perceiving the seriousness of various symptomatic behaviours

TABLE 5.07

RELATIONSHIP BETWEEN CONTACT WITH MENTAL ILLNESS AND SCORES ON THE INDEX OF EVALUATION OF SERIOUSNESS AND THE INDEX OF RECOGNITION OF MENTAL ILLNESS (percentages)

	Contact with Mental Illness							
Evaluation of Seriousness Index	Carina		The Gap		Recognition Index	Carina		The Gap	
	Yes	No	Yes	No		Yes	No	Yes	No
High scorers	28	23	30	18	High scorers	19	15	27	13
Medium scorers	57	53	52	59	Medium scorers	70	68	61	67
Low scorers	15	24	12	22	Low scorers	10	17	12	20
	(105)	(390)	(89)	(501)		(105)	(390)	(89)	(501)

and increases the likelihood that these behaviours will be identified as mental illness.

This finding was confirmed by information from two other questions about the respondent's experiences with mental disorder:

> Have you ever known anyone who was in hospital because of mental or nervous illness?
>
> Have you ever known anyone who has sought help from a doctor or a psychiatrist for mental or nervous illness?

Cross-tabulations revealed that sample members from both suburbs who answered those questions in the affirmative were more likely to be high on the index of evaluation of seriousness and the recognition index than respondents who gave negative answers (this is not reported in tabular form). The pattern overall, then, was that contact with mental disorder was related to the respondent's perception of the seriousness of the simulated case-histories and to the identification of mental illness. Thus this brief digression has been worthwhile. The data examined lend considerable weight to the assertion that the scales measure what they purport to - evaluation of the seriousness of symptomatic behaviour and recognition of mental abnormality. Finally, in the analysis to follow, use of the scales will obviate the need to cross-tabulate replies to each of the cases with the background variables because they provide a single measure over the eight items (for example, of recognition of mental disorder).[15]

SOME CORRELATES OF THE EVALUATION OF SERIOUSNESS AND THE RECOGNITION OF MENTAL ILLNESS

What factors influence sample members' perceptions of seriousness and the recognition of psychiatric disturbance?

The rest of this chapter will be concerned with a preliminary analysis of the relationship between important personal and demographic variables and scores on the two indices, in an attempt to isolate some of the main trends.

A good way to begin is with some factors that do not appear to be having an effect. Birthplace is the first of these: there was no relationship between a respondent's score on either scale, and whether he was born in Australia, Great Britain, Europe or elsewhere in the world. In a similar vein, whether the respondent spent most of his childhood in a city, provincial town or country area had no effect on scores on the evaluation of seriousness index or the recognition of mental illness index. Lastly, scores on the two indices were unrelated to three variables associated with suburban residence; satisfaction with neighbourhood, length of residence and the number of times the family had shifted in the previous ten years.

Sex differences were important however. Consider first the relation between the sex of the respondent and position on the evaluation of seriousness index. As Table 5.08 shows, men and women scored differently on that index, although the differences were only apparent with

TABLE 5.08

RELATIONSHIP BETWEEN SEX AND SCORE ON THE EVALUATION OF SERIOUSNESS INDEX (percentages)

Evaluation of Seriousness Index	Carina		The Gap	
	Male	Female	Male	Female
High	24	23	20	21
Medium	49	58	51	63
Low	27	19	28	17
	(191)	(299)	(251)	(338)

respect to medium and low scores. Males were more likely to be low scorers than females; 27% of males from Carina and 28% from The Gap were low scorers, compared to 19% of females from Carina and 17% from The Gap. On the other hand, females were considerably more likely to obtain a medium

score on the evaluation of seriousness index. Fifty-eight percent of Carina women and 63% from The Gap were in this category, the figures were 49% of Carina men and 51% from The Gap. Among the high scorers, differences between the sexes disappeared. Some 20% of males and females, from both suburbs, were high scorers. Generally speaking then, although the differences were small, the trend from the data was that higher scores were somewhat more likely among women - over 80% of them from Carina and The Gap obtained medium or high scores compared with around 70% of men.

Sex differences were more pronounced on the recognition of illness index (see Table 5.09 for details). Males were

TABLE 5.09

RELATIONSHIP BETWEEN SEX AND SCORE ON THE RECOGNITION OF MENTAL ILLNESS INDEX (percentages)

Recognition of Mental Illness Index	Carina		The Gap	
	Male	Female	Male	Female
High	18	13	17	14
Medium	70	68	67	65
Low	12	19	16	20
	(191)	(299)	(251)	(338)

more likely to be high scorers on the index than females. Eighteen percent of Carina men and 17% from The Gap were high scorers, the figures for women were 13% from Carina and 14% at The Gap. Looking at it the other way around, only 12% of Carina males and 16% from The Gap were low scorers, compared with 19% of Carina females and 20% from The Gap.

A few words of explanation are required here. The two prior Australian studies - Graves et.al. and Jordan, Earnshaw and Harper - did not find any patterned sex differences in the evaluation and recognition of mental disorders.[16] Why then, as this study shows, should males be more likely to identify psychiatric illness in the fictitious cases? And, perhaps paradoxically, why should females be rather more likely than males to perceive the seriousness of the cases? One possibility is that the sex differences uncovered in this investigation are spurious - arising from the special nature and composition of the samples (drawn from two suburbs in a single city). This seems unlikely for the trends, at least with respect to differences in the recognition of illness, were quite firm.

Are the data to be explained in terms of sex differences in experience with psychiatric disorder? Further analysis (not presented in tabular form) revealed that females reported contact with mental illness more often than males - for example, that someone from their household had needed help for a mental or nervous condition. While this information may help to explain the slight trend for women in both suburbs to be more likely to perceive the seriousness of the cases, it is difficult in the light of this to understand why males were the highest scorers on the recognition of mental illness scale. On a more speculative note, differential exposure of the sexes to the ideas and literature of the mental health movement may be a relevant factor. Yet it is not clear (and the data available are no help) whether males have greater familiarity with mental hygiene information and are thus more readily able to identify the symptoms and signs of mental illness; or, on the other hand, whether females have more contact with the mental health movement and, consequently, view the symptomatic behaviours in the cases more seriously than do male members of the samples. Obviously the limitations of the data at hand preclude any clear interpretation: it will be the task of future

studies - involving larger, more representative samples and doing more refined analyses - to ascertain more precisely the nature of the relationship between sex and the evaluation of seriousness and recognition of mental illness.

When the samples were divided according to age, a pattern emerged. First, consider the relationship between age and position on the evaluation of seriousness index. The trend is as indicated in Table 5.10.

TABLE 5.10

RELATIONSHIP BETWEEN AGE AND SCORE ON THE EVALUATION OF SERIOUSNESS INDEX* (percentages)

Evaluation of Seriousness Index	Carina			The Gap		
	21-25	26-45	Over 45	21-25	26-45	Over 45
High	18	24	25	13	22	21
Medium	49	54	58	67	56	60
Low	34	22	18	20	23	19
	(74)	(280)	(142)	(60)	(398)	(124)

*Respondent's age was collapsed into three categories according to trends in the data, to facilitate matrix analysis.

Clearly, older respondents (26-45 and over 45 years) were more likely to be high scorers than the younger ones (21-25 years of age). At Carina, where the trend was most noticeable, 34% of respondents in the lowest age group were low scorers on the evaluation of seriousness index, compared to only 18% of the oldest respondents. At the other end of the scale, 18% of the young respondents obtained a high score, while the figure was 25% for members of the Carina sample over 45 years of age. The situation was slightly different at The Gap. Age made a difference only among the high scorers; 13% of those 21-25 years old were high on the evaluation index, compared to 21% of respondents over 45 years of age. On the other hand, 20% of the youngest respondents and 19% in the oldest age category were low scorers.

The effects of age were more even on the recognition of mental illness scale and once again, scores on the index increased with age (Table 5.11). Beginning with the high scorers, only 9% of the youngest Carina respondents and 10% from The Gap were high scorers, while 25% from Carina and 19% from The Gap in the over 45 years category were high on the recognition index. On the other end of the scale, the pattern was almost as regular: 19% of the

TABLE 5.11

RELATIONSHIP BETWEEN AGE AND SCORE ON THE RECOGNITION OF MENTAL ILLNESS INDEX*

(percentages)

Recognition of Mental Illness Index	Carina			The Gap		
	21-25	26-45	Over 45	21-25	26-45	Over 45
High	9	13	25	10	15	19
Medium	72	68	67	67	67	60
Low	19	19	8	23	18	20
	(74)	(280)	(142)	(60)	(398)	(124)

*Respondent's age was collapsed, into three groups, in the same way as employed in the previous cross-tabulation.

youngest Carina respondents and 23% from The Gap were low scorers, the comparable figures for the oldest Carina respondents were 8% and 20% for their counterparts at The Gap. In sum then, age was related to evaluation of seriousness and to recognition of mental illness. Older respondents were more likely to perceive the seriousness of the behaviour in the fictitious cases and to identify them as examples of psychiatric pathology - a finding that is consonant with the results of an earlier investigation

in the Brisbane metropolitan area:

> Age was found to be an important factor in the recognition(and referral) of mental illness... In general, the older age groups expressed a view more similar to the psychiatrists regarding the extent of pathology and suggested medical referral more often than the younger age groups.[17]

How are the effects of age on the evaluation of seriousness and the recognition of illness to be explained? For a start, the amount of contact the respondent had with psychiatric illness does not appear to be a relevant factor: an analysis of the data (not reported here) revealed no relationship between the age of the respondent and the amount of experience with mental disturbance they reported. On the other hand, it may be that older sample members have been more exposed to the messages of the mental hygiene movement than younger respondents. Consequently, they will be better equipped to identify the signs of mental illness and they will be more likely to perceive the serious nature of the symptomatic behaviours depicted in the cases. This however, is speculation. The nature of the survey data do not permit a 'test' of such an hypothesis which, along with a more exhaustive analysis of the relation between age

and the evaluation of seriousness and recognition of illness, must await further Australian research.

Finally, is social status related to the evaluation of seriousness or to the identification of mental abnormality? Two common measures of socio-economic status, education and occupation, are used to assess this question. The relationship between level of education and score on the evaluation index is presented in Table 5.12.

TABLE 5.12

RELATIONSHIP BETWEEN EDUCATION AND SCORE ON THE EVALUATION OF SERIOUSNESS INDEX (percentages)

Evaluation of Seriousness Index	Carina			The Gap		
	Primary	Second-ary	Tertiary	Primary	Second-ary	Tertiary
High	24	21	27	22	19	22
Medium	51	58	53	61	60	56
Low	26	21	20	18	21	21
	(180)	(214)	(30)	(102)	(292)	(103)

The situation is by no means clear-cut. At Carina, there was some evidence that education was influencing the evaluation of seriousness but with the small numbers in some cells of the matrices, the data are inconclusive. Sample members with tertiary education (27%) were somewhat more likely to be high scorers than those who had been educated to primary school standard only (24%). Similarly, tertiary educated respondents (20%) were less likely to be low on the index than those who had been no further than primary school (26%). However these rather slight differences disappeared among The Gap sample - 22% of those with tertiary education and 22% of respondents who had attended no further than primary school were high scorers.

From the data in Table 5.13 it can be seen that level of education was exerting a stronger influence on scores on the recognition of mental illness index. Considering the high scorers first; 20% of the Carina tertiary educated respondents and 23% from The Gap were high on the recognition index, the figures for sample members with primary schooling only were 18% and 15% for Carina and The Gap respectively. Yet it was sample members with secondary education who provided the smallest proportion of high scorers - 12% at Carina and 13% at The Gap. The effects of education on

TABLE 5.13

RELATIONSHIP BETWEEN EDUCATION AND SCORE ON THE RECOGNITION OF MENTAL ILLNESS INDEX

(percentages)

Recognition of Mental Illness Index	Carina			The Gap		
	Primary	Secondary	Tertiary	Primary	Secondary	Tertiary
High	18	12	20	15	13	23
Medium	70	67	70	67	68	64
Low	12	21	10	18	18	13
	(180)	(214)	(30)	(102)	(292)	(103)

identification of mental illness were visible again on the opposite end of the scale. Ten percent of tertiary educated respondents from Carina and 13% from The Gap were low scorers, compared to 12% of Carina respondents with primary education only and 18% from The Gap. A considerable proportion of respondents who had gone no further than secondary school were low scorers (21% from Carina, 18% from The Gap). To summarize, education was related to recognition of mental illness; the tertiary educated members of the samples were rather more likely to identify the

behaviours in the case-histories as psychiatric abnormality: however, the effects of education on the evaluation of seriousness - which were at best minimal - were confined to the Carina sample.

Turning last to an examination of the influence of occupation, the evaluation of seriousness index and the occupational level of the head of the household were cross-tabulated in the usual manner. This revealed that respondents from high status home backgrounds were no more likely to be high scorers than persons from blue collar homes (Table 5.14). For example, 26% of Carina respondents from professional and

TABLE 5.14

RELATIONSHIP BETWEEN OCCUPATIONAL STATUS AND SCORE ON THE EVALUATION OF SERIOUSNESS INDEX (percentages)

Evaluation of Seriousness Index	Carina			The Gap		
	P-M*	C-S	M	P-M	C-S	M
High	26	24	24	20	25	18
Medium	52	54	54	56	56	60
Low	22	22	22	24	18	22
	(86)	(124)	(252)	(256)	(157)	(162)

*P-M = Professionals and managers; C-S = clerical and sales workers; M = manual workers.

managerial-executive homes and 20% of their counterparts at The Gap were high scorers, compared with 24% from manual working backgrounds at Carina and 18% from The Gap.

As with education, occupation exerted a rather stronger influence on the identification of mental illness. The details are presented in Table 5.15 and it can be seen

TABLE 5.15

RELATIONSHIP BETWEEN OCCUPATIONAL STATUS AND SCORE ON THE RECOGNITION OF MENTAL ILLNESS INDEX (percentages)

Recognition of Mental Illness Index	Carina			The Gap		
	P-M*	C-S	M	P-M	C-S	M
High	17	15	15	19	11	11
Medium	69	69	68	64	68	67
Low	14	17	17	16	20	22
	(86)	(124)	(252)	(256)	(157)	(162)

*P-M = professionals and managers; C-S = clerical and sales workers; M= manual workers.

that occupational status was directly related to position on the recognition index. Although the trend was quite weak at Carina, sample members from professional a nd managerial-executive homes were more likely to be high scorers than

persons from clerical-sales and blue collar backgrounds. For example, 17% of Carina respondents and 19% at The Gap from professional and managerial-executive households were high scorers, the comparable figures for respondents from manual working homes were 15% and 11% for Carina and The Gap. The trend is, of course, reversed at the other end: 14% from professional and managerial-executive homes at Carina and 16% from The Gap were low scorers on the recognition index, compared with 17% from blue collar homes at Carina and 22% from The Gap. Interestingly, respondents from clerical and sales homes scored very similarly to persons from blue collar backgrounds and this happened in both suburbs. Last, it is worth noting that, as was the case with education, the occupational differences on the index of recognition were stronger at The Gap than at Carina.

To sum up then, what effect did social status have on the evaluation of seriousness and the identification of mental disorder? The two measures of socio-economic position - education and occupation - produced some patterned differences on the recognition index: higher status respondents were generally the most likely to be high scorers on that scale. The influence of education

and occupation on the evaluation of seriousness index was by no means as strong - in fact, in the case of occupation it was negligible; there was however some slight evidence that higher socio-economic status respondents were rather more likely to be high scorers than low status respondents.

These findings are generally in accordance with the results of previous investigations here in Australia and elsewhere.[18] Why, though, is socio-economic standing related to the evaluation and recognition of mental illness, or, more pertinently, why should higher status respondents be more likely to recognize the symptoms of mental disorder? Experience with psychiatric illness is probably not a relevant variable; data presented earlier in this report (Chapter 4) revealed little or no relationship between socio-economic status and contact with the mentally ill. A plausible explanation would seem to lie in the direction of social class differences in exposure to the ideas of the mental hygiene movement. It could reasonably by hypothesized that the better educated and those in professional and managerial positions will be more familiar with the goals of the mental health movement,

and therefore more able to recognize psychiatric abnormality. Such an hypothesis cannot be tested from the questions asked in the Carina - The Gap study; it awaits confirmation (along with other speculations about the relationship between class and the perception recognition of mental illness) from further research on broader-based Australian samples.

SUMMARY

It will be appropriate to end this chapter with a brief review of the main points covered. The focus of the discussion was upon two aspects of the responses of sample members to simulated cases of mental illness; the perception of seriousness and the identification of psychiatric disturbance.

Replies to the eight case-histories indicated, in general, a low level of awareness of the seriousness of the psychiatric symptoms portrayed in the vignettes. In fact, only two of the cases were seen by anything like substantial numbers of respondents to be very serious, and this trend was the same in Carina, the low status area, and The Gap, the high status suburb. The pattern of responses to the cases was essentially similar for the

identification of mental illness; only one case was recognized as psychiatric illness by a majority of sample members. However, there were some differences between the suburbs on the eight identification items - the pattern was, surprisingly, for somewhat higher levels of recognition of mental illness at Carina, the blue collar suburb.

Yet the overwhelming fact about the responses to the cases was that they revealed an alarmingly low level of knowledge about psychiatric illness in the two suburban samples. Clearly, the bulk of the respondents did not perceive the seriousness of the cases and they were not able to recognize that the behaviours depicted in them were evidence of psychiatric pathology. While it is important to keep in mind the limitations of the present study - restricted as it is to two suburbs in a single Australian city - it is equally clear that the data have serious implications for the mental hygiene movement. Members of the community, or so it seems, will not be able to recognize the symptoms and signs of mental disorder in either their own or other's actions and therefore they will be unlikely to seek or to recommend treatment for such conditions. Under these circumstances, any concept of

preventive psychiatry based on "early diagnosis and therapy to prevent further development of symptoms" (as Redlich and Freedman[19] put it) will be thwarted. In addition, there may be other, even more grave complications of failure to utilize psychiatric treatment services; for example, the problem of suicide with respect to endogenous depression was mentioned earlier.

The task is clear for the 'helping professions' (psychiatry, psychology, social work): wide and rapid dissemination of information about mental illness is imperative. Members of the community must learn to recognize the symptoms of psychiatric impairment and to appreciate their seriousness; as well, they must know about the appropriate places to seek therapeutic intervention. In large part, this can be achieved through campaigns in the mass media (the press, radio and television). To this end, some small but important beginnings have been made when, for example, Queensland established its first Mental Health Week in 1971, "to draw public attention to the great social problem of mental illness."[20] This campaign received coverage in the local press which quoted the convenor of an organizing committee as saying;

> We are concerned at the lack of public awareness of the severity of the problem.[21]

However, these mental health 'messages' must be geared to and must reach all sections of the community if they are to be successful. Rossi and Blum have warned of the problems of differential exposure to the mass media:

> Studies of book-reading and exposure to newspapers, magazines, radio, and television indicate that upper socio-economic status persons read,listen and view more than lower socio-economic status persons and, furthermore, expose themselves to materials of greater complexity and difficulty. Hence, the articles in newspapers and magazines that discuss such topics as child-rearing practices or diet are more likely to be read by upper socio-economic status persons.[22]

There are good reasons to be concerned about this with respect to information on psychiatric matters. Some considerable time ago, Kingsley Davis pointed to the middle class bias in mental health communications and this has been taken up more recently by other sociologists.[23] Data from the Carina-The Gap study show a low level of comprehension of psychiatric matters and they indicate, tentatively at least, that recognition of mental illness is likely to be highest among persons from the upper socio-economic strata of society.

One final point about the overall level of the perception of seriousness and recognition of mental disorder. During the 1960's and 70's, the labelling theory or societal reactions perspective as outlined by Scheff has been one of the most persuasive and influential sociological approaches to the study of psychiatric illness.[24] Very briefly, this approach focusses on the processes by which families, employers, police and others come to label some deviant behaviour as mentally disordered, thereby setting in motion complex changes in social expectation and self-conception that sometimes eventuate in hospitalization. Walter Gove has, however, marshalled evidence (mostly from studies using simulated case-abstracts) that this orientation is based on assumptions that are inconsistent with what is known: principally, that people strongly resist seeing deviant behaviour as mentally disordered; the pressures, instead, are to interpret even grotesque behaviour as somehow normal and explicable.[25] Responses to the simulated cases of mental illness used in this investigation tend to support Gove; any explanation of mental illness, these data indicate, will have to take into account low levels of evaluation of the seriousness of abnormal acts and low levels of recognition of psychiatric disorder.

The rest of the chapter was concerned with the question; what factors effect the evaluation of seriousness of psychiatric symptoms and the identification of mental illness?

As might be expected, the amount of contact the respondent had with mental illness made a difference. Sample members who reported personal experience with the mentally ill were more likely than those who had no such contact to perceive the seriousness of the symptomatic behaviours in the cases and to be able to recognize mental disorder. The analysis that followed revealed that sex differences were important: females were rather more likely to see the seriousness of the cases, males were more likely to identify the cases as psychiatric pathology. Age was important too. Older respondents were most likely to view the case-abstracts as being serious and to identify them as mental illness. Finally, socio-economic status was examined and found to be related to the recognition of mental illness and, much less strongly, to the evaluation of seriousness. Higher status respondents were more likely than respondents of lower status to recognize the symptoms of psychiatric illness and somewhat more likely to perceive the seriousness of the behaviour in the cases.

There is a final point to be made about the analysis of the influence of the various background variables. The analysis presented here should not be seen as by any means exhaustive, instead, it was a preliminary investigation of some personal and demographic factors to determine the main trends. Of necessity it was a simple analysis, for example, because of the small numbers involved in some cells of the matrices. Thus it focussed on the effects of single variables, such as age, sex or education, rather than looking at the interplay of factors in an attempt to sort-out the causal priorities involved in, say, differences in the recognition of mental illness. It is apparent that detailed analyses on larger samples more representative of the Australian community are required. Yet it is equally apparent that the present study has highlighted some profitable directions that future Australian research on social class and mental illness might follow.

CHAPTER VI

KNOWLEDGE OF WHERE TO SEEK HELP

Knowledge about where to find a psychiatrist and help for marital and financial problems is discussed in this chapter. It opens with a discussion of some theoretical issues concerning information about where to get help. This is followed by an analysis of replies to a number of questions regarding the sample members level of knowledge about where to obtain psychiatric, marital and financial assistance. Next, a knowledge index is constructed based on responses to those questions. Finally, the correlates of knowledge are explored, and the analysis focusses on the impact of socio-economic status as well as other personal and demographic variables.

INTRODUCTION

At this stage it might be helpful to review briefly what has been done. The data analysis began with an examination of the cases collected in the Psychiatric Morbidity Census of Carina and The Gap; next, information

obtained in the questionnaire Survey was analyzed, beginning with the responses to eight simulated cases of psychological disorder. This indicated a low level of evaluation of the seriousness of symptoms of psychiatric illness and a low level of recognition of the behaviours in the cases as mental illness. In addition, there was considerable evidence that recognition of mental illness in the cases (and perhaps the evaluation of seriousness) was related to the socio-economic status of the respondent. Yet it is important to realize that there is more to receiving psychiatric treatment than simply recognizing (and acting on) the symptoms of mental illness: the person must know where to go for help.

In this chapter it is intended to take up some important but neglected aspects of the problem of psychiatric treatment - do members of the community know where to obtain treatment for mental illness? One of the most rapidly growing areas of sociological theory and research has been in the field of study that David Mechanic called "illness behaviour and the help-seeking process."[1] Something of the flavour of this work can be gauged from the following statement by Mechanic:

> On the most simple and obvious level, it is plain that symptoms are differentially perceived, evaluated, and acted upon (or not acted upon) by different kinds of people and in different kinds of situations.[2]

Some of the principal theoretical and empirical concerns have been; knowledge about illness and the recognition of symptoms, preventive health behaviour, attitudes towards medical care and health agencies, patient-physician relations and the sick-role.[3] However, while the focus of such research is on the problematical nature of medical and psychiatric treatment (that is, seeking help is not seen as an 'automatic' or inevitable response to falling sick), little or no work has been done on whether persons know where to obtain treatment, or further, whether knowledge about treatment facilities is differentially distributed in the population - for example, in certain age and socio-economic groups.

A review of the literature in the sociology of medicine reveals a dearth of empirical studies on the problem and indeed, Mechanic devotes only a couple of lines to the topic;

> ...it is probable that once having defined the need for treatment, patients in the various class groups have different information and knowledge concerning how to arrange psychiatric intervention.[4]

It will be the task of this chapter to explore the sample members' knowledge of where to find psychiatric services and to throw some light on the validity of Mechanic's assertions. Further, it is intended to cast the net wider, to look at whether, in fact, respondents know where to find help for other kinds of problems - marital and financial.

THE KNOWLEDGE ITEMS

A good way to begin is with a simple tabulation of replies to the question

> Now, suppose you did have a problem and wanted to talk to a psychiatrist. Would you know where to find one?

The data are presented in Table 6.01, and the interesting thing is the high level of knowledge claimed by respondents. This is rather surprising when viewed in relation to the data in the previous chapter on perception of the seriousness of symptoms and recognition of mental illness. As well, it

TABLE 6.01

KNOWLEDGE ABOUT WHERE TO FIND A PSYCHIATRIST: CARINA AND THE GAP SAMPLES (percentages)

Knowledge	Carina	The Gap
Yes	70	72
Not sure, depends	3	5
No*	24	21
D.K., N.A.	3	1
	(500)	(596)

*This includes one respondent from Carina and one from The Gap who replied "would never need one" as provided by the pre-coded alternatives.

is interesting to note that there were no differences between Carina, the blue collar suburb, and The Gap, the middle class area: 70% of the Carina sample and 72% from The Gap said that they would know where to find a psychiatrist. Unfortunately there are no comparative figures - either Australian or overseas - with which to match these data; this of course raises the whole question of what is an acceptable or a desirable level of community knowledge about such matters. But it is not an easy

question to answer. Part of the answer lies in the experiences and understanding of mental health professionals: do they feel that there is an adequate level of knowledge of where to find psychiatric help in the community at large? Part of the answer also, lies in epidemiological research to assess the number of persons in the community with untreated illness because of lack of knowledge of where to seek aid.

Following the query "would you know where to find a psychiatrist", the obvious question to ask next is; where would you go? Consequently, sample members who had answered either "yes" or "not sure" were asked:

> What would you do? How would you go about finding a psychiatrist?

Their replies are given in Table 6.02 and these figures may be most fruitfully considered in relation to the Morbidity Census data on the use of psychiatric facilities, presented in Chapter 4.

TABLE 6.02

WHERE RESPONDENTS WOULD GO TO FIND A PSYCHIATRIST:

CARINA AND THE GAP SAMPLES (percentages)

Source	Carina	The Gap
Ask local or family doctor to recommend one	47	58
Go to nearest public hospital	19	7
Local government psychiatric clinic	14	12
Consult a private psychiatrist directly	14	13
Other, D.K., N.A.	7	11
	(375)	(464)

Nineteen percent of the Carina sample compared to only 7% from The Gap stated that they would go to the nearest public hospital and these differences were reflected in the figures for the actual use of psychiatric services - Carina residents were much more likely to be found at general public hospitals than persons from The Gap. Similarly, Table 6.02 shows that sample members from Carina (14%) and The Gap (12%) were about equally likely to have said they would go to the nearest government psychiatric

clinic; a situation matched by their actual patterns of use of that service in Brisbane. On the other hand, although 14% from Carina and 13% from The Gap said they would consult a private psychiatrist directly, the Psychiatric Morbidity Census prevalence figures show that, in fact, residents of The Gap were much more likely to be found in treatment with a private psychiatrist. There were suburban differences observed in the frequency with which respondents stated they would use their local or family doctor to refer them to a psychiatrist. Forty-seven percent of the Carina sample and a rather higher proportion from The Gap, 58%, would seek the services of a psychiatrist in this way.[5] This is by far the most popular resource, for sample members from both suburbs.

Finally, it is pleasing to find that only two respondents (one from each suburb) said they "didn't know" where they would go to find a psychiatrist (they have been placed in a single category with the "other" responses and "no answers" in Table 6.02). It is likely then, that the figures in Table 6.01 represent an accurate picture of the respondents' knowledge about where to find a psychiatrist.

When pressed for specific details of how they would do so, the overwhelming majority of those who had claimed knowledge were able to describe the steps they would take.

To sum up, it seems that in the Australian situation at least, Kadushin was being unduly pessimistic when he said:

> Individual psychotherapists and psychiatric clinics are quite unknown to the general public, and merely finding a good therapist (or any therapist) is a serious problem for potential psychiatric patients.[6]

The data from the Carina-The Gap survey indicate a relatively high level of information about where to locate psychiatric treatment. Some 70% of the total sample claimed they would know where to find a psychiatrist if they needed one, and further questioning revealed a wide and realistic range of options favoured by respondents.

Would sample members know where to seek help for marital and financial difficulties if they had occasion to? Immediately following the items about psychiatric facilities, respondents were questioned about their knowledge of where to obtain help for marital and financial problems. The data appear in Table 6.03.[7]

TABLE 6.03

KNOWLEDGE ABOUT WHERE TO FIND HELP FOR MARITAL AND FINANCIAL PROBLEMS: CARINA AND THE GAP SAMPLES (percentages)

Knowledge	Marital Problems		Financial Problems	
	Carina	The Gap	Carina	The Gap
Yes	67	78	67	75
No	25	20	26	22
Not sure, D.K., N.A.	8	3	7	4
	(500)	(596)	(500)	(596)

The situation was much the same as with knowledge about where to find a psychiatrist. Overall, the general level of knowledge was, relatively speaking, quite high. This is a good thing because marital and financial problems are endemic in Australian society: a number of commentators have recently drawn attention to the frequency of marital discord, the amount of poverty and the nature and extent of financial troubles in the community.[8] Should the need arise, however, most respondents in the Carina-The Gap survey would be well informed about where to obtain financial aid or help with marital difficulties. For both kinds of problems though, there seemed to be a slight

trend for residents from The Gap to be more likely to respond positively. Sixty-seven percent of the Carina sample said they would know where to obtain help for marital problems, the figure was 78% for The Gap respondents. For financial problems, the figures were 67% from Carina and 75% from The Gap.

Once again, respondents who had claimed knowledge were asked to specify where, in fact, they would go to be helped for problems about a marriage or if they were in financial trouble. The details are given in Table 6.04.

TABLE 6.04

WHERE RESPONDENTS WOULD GO TO FIND HELP FOR MARITAL AND FINANCIAL PROBLEMS: CARINA AND THE GAP SAMPLES (percentages)

Source	Marital Problems		Source	Financial Problems	
	Carina	The Gap		Carina	The Gap
Family or local doctor	7	8	Government Relief assistance Branch	2	1
Marriage Guidance Bureau	72	73	Other government welfare (e.g. Social Services, Childrens Services)	11	8
Psychiatrist	2	2			
Clergyman	9	9	Non-government Welfare agency	6	7
Family Welfare Agency	2	3	Credit Unions, banks	44	55
Older relative or friend	2	0	Other D.K.,N.A.	37	29
Other, D.K., N.A.	5	4			
	(370)	(470)		(363)	(458)

Turning first to marital problems, there are two observations to be made about the data. One is the similarity in the patterns of response made by sample members from Carina, the blue collar area, and The Gap, the middle class suburb. The other point is that the bulk of respondents (72% from Carina and 73% from The Gap) nominated a Marriage Guidance Bureau as the place to obtain help in times of marital disharmony. That so many persons were able to identify what is probably the most appropriate community resource for these problems must surely be a matter for satisfaction to counsellors in the marriage guidance field. The remainder of the replies were divided among 'local or family doctor', 'psychiatrist', 'clergyman', 'family welfare agency' (all of which are places or persons capable of giving help or making a suitable referral) and 'older relatives or a wise friend.' Finally, only one respondent, from Carina, was unable to specify exactly where he would seek help.

Looking at responses to the question about services for people in financial difficulties, the situation is not quite so clear. For a start, the data are by no means as informative because of the large proportion of responses

falling into the 'other', 'don't know' and 'no answer' category. Of these, there were sixteen Carina respondents and six from The Gap who said they "didn't know", when pressed for details of how they would find financial help. Interviewers in the Survey had been instructed to record any replies other than those provided for by the pre-coded alternatives. An examination of these showed that informal resources - friends or relatives - were the ones most frequently mentioned.[9]

Many respondents indicated that they would seek financial help in times of hardship from either a bank or a credit union: 44% from Carina and 55% from The Gap said they would do so. These figures reveal interesting and fairly substantial areal differences between the blue and white collar suburbs. Perhaps the residents from The Gap are somewhat better able to use credit facilities than people from the mainly working class suburb, Carina. The remainder of the respondents would look to various kinds of social welfare services for help and here there were no differences in the replies from sample members from Carina and The Gap. Thirteen percent of Carina respondents and 9% from The Gap would turn to one of the government

welfare services, while 6% from Carina and 7% from The Gap would go to 'voluntary' or non-government welfare agencies.

To sum up so far, the Survey data have shed some light on an important but neglected area of the sociology of medicine and, in general, the 'sociology of help-seeking': knowledge of where to obtain treatment for psychiatric illness and help for marital and financial problems. Evidence from the study of Carina and The Gap indicates that most members of the community would know where to find help for these kinds of troubles if the necessity arose. There are limitations on the scope of this study of course, for example it is restricted to two suburbs in one city; however, it is clear that these results have highlighted the need for future research in vital but virtually uncharted areas - such as the relationship between recognition of the signs of mental disorder and knowledge about psychiatric services. For instance, if a person becomes severely disturbed (in an acute psychotic episode) will he be able to make use of his own knowledge of treatment facilities and would he take advice from others who urge him to seek help?

It is now time to turn to a question raised earlier in this chapter; is knowledge about where to find a psychiatrist (and help for marital and financial problems) related to socio-economic status? A cross-tabulation of replies to the knowledge question by the occupational level of the head of the respondent's household and by the respondent's educational level appears in Table 6.05.

The trend across both suburbs is clear and consistent. Knowledge about where to find a psychiatrist is related to socio-economic standing, on the two measures used. Sample members from the top of the status hierarchy were the most likely to have said they would know where to seek the services of a psychiatrist. Yet, it is clear from the data, the majority of low status respondents (on occupational and educational rank) say they would know where to find psychiatric treatment.

TABLE 6.05

SOCIO-ECONOMIC STATUS AND KNOWLEDGE ABOUT WHERE TO FIND A PSYCHIATRIST: CARINA AND THE GAP SAMPLES (percentages)

Occupation of Head of Respondent's Household	Carina			The Gap		
Knowledge	P-M*	C-S	M	P-M*	C-S	M
Yes	79	73	66	79	67	65
Not sure, depends	3	2	4	5	5	7
No	17	25	26	15	27	27
	(86)	(124)	(252)	(256)	(157)	(162)

*P-M = professional and managerial workers; C-S = clerical and sales workers; M = manual workers.

Respondent's Education level	Carina			The Gap		
Knowledge	P**	S	T	P	S	T
Yes	66	70	80	61	70	83
Not sure, depends	5	2	3	5	7	3
No	26	26	13	33	23	13
	(180)	(214)	(30)	(102)	(292)	(103)

**P = attended or completed primary school only; S = attended or completed secondary school; T = tertiary or university attended or completed.

Bearing in mind the limits of the Carina-The Gap study, it looks as though Mechanic's assertion that "the various class groups have different information and knowledge concerning how to arrange psychiatric intervention,"[10] applies to the Australian situation.

There are two things to be said about this. First, there is a 'why' question; it is not enough in social science to demonstrate a relationship between phenomena, they require explanation as well. The limited survey data available preclude any kind of a satisfactory interpretation here but the problem is a general one that has been touched on in the previous chapter. White collar people, especially those in professional and administrative positions, tend to have the highest exposure to mass media sources of mental hygiene information that advocate psychiatric consultation for troubles of a socio-emotional kind. In this context, information is likely to be available about the location of psychiatric services. Thus white collar people are more likely to be 'psychologically-minded' (as the mental health jargon goes) and to know where to look for psychiatric treatment. However it should be recognized that this is more in the nature of an hypothesis for future testing, rather than an empirically grounded statement of fact.[11]

Second, the data strongly suggest that the blue collar members of the community - who, it will be remembered, require psychiatric treatment in large numbers - may well have the greatest difficulty in obtaining psychiatric help simply because many of them lack knowledge about where to find it. Nor should this finding be overlooked; it adds yet another factor to the catalogue of biases against the working class psychiatric patient.[12] As well, in the context of the present study it may have explanatory value. Although the Psychiatric Morbidity Census uncovered more than twice as many cases at Carina (the blue collar area) as at The Gap (the middle class suburb), subsequent analysis of the data by the patient's occupational status revealed no relationship between socio-economic standing and the amount and type of mental illness. One serious possibility is that the Morbidity Census of cases in treatment underestimated a number of blue collar persons (from both suburbs) who were mentally ill but who did not present for treatment simply because they or their relatives did not know where to obtain help.

Finally, there are two matters to be mentioned briefly. The cross-tabulation by socio-economic status was run again in relation to knowledge about where to seek help for marital and financial problems. For space reasons these data are omitted, however the results mirrored the influence of social status on knowledge about psychiatric help - higher status respondent's were more likely than persons lower down on the socio-economic ladder to say that they would know where to find help in times of marital difficulties or financial hardship. Last, the relationship between socio-economic status and where the respondent specified finding a psychiatrist and seeking marital and financial help was explored (this is not reported in tabular form). The results were as follows: while there was some slight evidence that socio-economic status was related to help-seeking (for example, higher status persons preferred a private psychiatrist), there was no relation observed between social standing and where the person stated they would go in times of marital and financial crisis. Because of the small numbers in some of the cells in the cross-tabulations, these results should be viewed with caution;[13] it is important, however,

that more conclusive research be done in the near future on the relation between social status and this aspect of help-seeking behaviour.

THE KNOWLEDGE INDEX

So much then for the overall pattern of responses to each of the knowledge items. The immediate question is; what does this mean for an individual's general level of knowledge about where to seek help? Does it mean that a person who knows where to find a psychiatrist for example, will also know where to seek help in a marital crisis or, if the need arises, find financial assistance? In short, it is the problem of whether a single dimension or common element runs through the three items - in this case, knowledge about various kinds of facilities. The procedure to be followed in determining whether, in fact, the items are related will be the same as that used in the construction of the indices in the previous chapter.

Respondents were scored 1 for each time they said 'yes' to one of the three knowledge items, all other responses were scored 0. Consequently, they could score from zero to three on the final index; a 0 represents a respondent

who wasn't able to say that he could find a psychiatrist, marital help or financial assistance, while a 3 represents someone who was knowledgeable on all three items. Then a set of item-total correlations was calculated to determine the extent to which there was a correlation between item score and total score. Table 6.06 presents the item-total correlations and they are all significantly different from zero at better than the .01 level of confidence - fairly good evidence for concluding that a single dimension (knowledge about facilities) runs through these items.

TABLE 6.06

ITEM-TOTAL CORRELATIONS: THREE KNOWLEDGE ITEMS (N=1,096)

Item	Item-total Correlations
Find a Psychiatrist	0.47
Find marital help	0.50
Find financial help	0.35

The distribution of respondents over the index is presented in Table 6.07. As can be seen, only 63 respondents (6% of the total) scored 0 and a further 203 (19%) scored 1. For the purposes of analysis, scores

on the index will be trichotomized; those who score 0 and 1 will be combined into a single category, the 'low' scorers, those who scored 2 will be called 'medium' and those with 3 will be called 'high' scorers on the knowledge

TABLE 6.07

DISTRIBUTION OF SCORES ON THE KNOWLEDGE INDEX (N=1,096)

Score		Frequency	Percent
Low	0	63	6
	1	203	19
Medium	2	336	31
High	3	494	45

index. Obviously, then, the distribution is skewed towards the 'high' knowledge end of the index. A significant proportion of the Carina-The Gap samples (45%) would know where to find help for all three kinds of problems (psychiatric, marital and financial) covered in the Survey, while another third of the respondents would know where to go for help for at least two of the problems. Last, it is worth mentioning that there were areal differences on the index, residents from the blue collar suburb were not as likely to be high scorers.

Thirty percent of the Carina sample were low scorers, while 20% from The Gap were in that category. Similarly, 41% of Carina respondents were high scorers on the knowledge index, the figure was 49% from The Gap.

THE CORRELATES OF KNOWLEDGE

The next step is to examine the personal and social correlates of knowledge about resources for help in times of psychiatric, marital or financial crisis. This time the analysis opens by focussing on the central concern of this report - the influence of socio-economic status. First, scores on the knowledge index were cross-tabulated with the respondent's educational level and the details appear in Table 6.08.

TABLE 6.08

RELATIONSHIP BETWEEN RESPONDENT'S EDUCATIONAL LEVEL AND SCORE ON THE KNOWLEDGE INDEX: CARINA AND THE GAP SAMPLES (percentages)

Knowledge Index	Carina			The Gap		
	P**	S	T	P	S	T
Low	42	24	20	30	19	12
Medium	32	31	20	37	36	22
High	26	45	60	33	45	66
	(180)	(214)	(30)	(102)	(292)	(103)

**P=attended or completed primary school only; S=attended or completed secondary school; T=tertiary, or attended or completed university.

The influence of education is clearly visible. Higher status respondents - the ones who had attended or completed university - were most likely to be high scorers, followed by those with secondary schooling and then, the group least likely to be high on the knowledge index, the respondents with only primary school education. Clearly then, social standing as measured by the level of education of sample members was related to knowledge about facilities. But the effects of suburban residence showed through as well. Across each of the levels of education, respondents from The Gap were more likely to be high scorers than their Carina counterparts.

Predictably, similar results were obtained when the cross-correlation was run again for the influence of the occupational level of the head of the respondent's household. The figures appear in Table 6.09 and it can be seen that sample members from professional and administrative home backgrounds were most likely to be high scorers, next were respondents from other white collar households and, least likely to be high scorers were those from blue collar backgrounds. In short, respondents from high status households were most likely to be high scorers on the index, though here again the influence of suburban residence was apparent.

TABLE 6.09

RELATIONSHIP BETWEEN OCCUPATIONAL LEVEL OF HEAD OF RESPONDENT'S HOUSEHOLD AND SCORE ON THE KNOWLEDGE INDEX: CARINA AND THE GAP SAMPLES (percentages)

Knowledge Index	Carina			The Gap		
	P-M**	C-S	M	P-M	C-S	M
Low	18	26	33	15	21	24
Medium	27	31	31	25	38	38
High	55	44	36	59	40	38
	(86)	(124)	(252)	(256)	(157)	(162)

**P-M = professional and managerial workers; C-S = clerical and sales workers; M = manual workers.

The data on socio-economic status and knowledge about facilities may be summed-up thus: the higher the respondent's socio-economic position, the greater the likelihood of him knowing where to seek help in times of a psychiatric, marital or financial emergency. This trend was observed when both measures of social status were used. The data lend useful empirical weight to Kaplan's commonsense but unsupported assertion that, not only are highly educated people more likely to define their problems in mental health terms and more likely to be disposed towards seeking help -

> the decision to take such action is facilitated because more highly educated people are also more likely to have information on the availability of resources.[14]

For many members of the working class, obtaining help for psychiatric, marital or financial problems will be made difficult simply because of their lack of knowledge of the whereabouts of the appropriate facilities. The implications of this should not be missed: if an adequate response is to be made to social problems such as mental illness, marital discord and poverty, Australian mental health and welfare institutions - specifically, the agencies in the front lines of the battle - must become more visible to those in need of their services.[15] Because of their lack of knowledge of such things, blue collar members of the community will be unlikely to make good use of the existing resources and facilities - or so it appears from the Carina-The Gap survey data.

A possible explanation of the relationship between socio-economic position and knowledge about resources was foreshadowed in the discussion of knowledge about psychiatric help earlier in this chapter. It was suggested that class differences in attention to the mass media led to

differences in exposure to mental hygiene information with the result that higher status persons were more likely to know where to find a psychiatrist. Knowledge about other kinds of problem-solving resources such as marriage guidance services may very likely be obtained in the same way.[16] Finally, there is another interesting interpretation worthy of consideration: it might be enlightening to place the observed relation between social status and knowledge about services and resources in the context of the theoretical and empirical work done by Almond and Verba on citizen's knowledge of political and administrative affairs.[17] These authors were concerned to demonstrate the importance for democratic government of knowledge and feelings about various institutions such as government bureaucracies, and their research indicated the relevance of social status as an explanatory variable. It may be profitable to view knowledge about problem-solving services in the more general framework of information and feelings about socio-political and administrative institutions. Hollingshead and Redlich in their original study in the 1950's on social class and mental disorder, made this point about the relevance for psychiatric treatment of lower class attitudes towards community

facilities; "A deep-seated distrust of authority pervades class $\overline{V}$ persons from childhood to old age. Suspicion is directed toward police, clergymen, teachers, doctors, public officials, public health nurses, and social workers... Institutions for care of the disabled and the ill are believed to be run for money and one has to have 'pull' to get into them."[18] These remarks were written about the American situation nearly twenty years ago, yet they may provide some insights into the relatively low level of knowledge which blue collar people have about helping services: their negative experiences and attitudes are unlikely to lead them to actively seek out information about these facilities. This however, is clearly a matter to be pursued in future research.

It is now time to turn to a consideration of some other possible correlates of knowledge about problem-solving facilities. An obvious one of course, is the respondent's experiences with mental illness and other social problems. Three items on the questionnaire dealt with contact with mental illness and a cross-tabulation of the knowledge index by responses to them revealed a

predictable result.[19] Sample members who reported contact with the psychiatrically disturbed were more likely than those without such experience to be high scorers on the knowledge index. This makes good sense, one might reasonably expect that information about helping services would be passed on in social interaction with the mentally ill - the very people who use such services. Or, it could be simply through observation of the help-seeking activities of the mentally disturbed, for example one of the respondent's relatives or friends may have sought psychiatric care.

However, whether or not the respondent had ever needed professional help for a problem was not related to his knowledge about such services. Cross-tabulation of the knowledge index by replies to the question "have you ever wanted advice or had a problem for which professional help (such as a psychiatrist or a social worker) would have been useful"[20] revealed no trend. In other words, although contact with people with psychiatric problems was likely to be associated with knowledge about helping facilities, having problems of their own made no difference to the respondent's level of knowledge.

When the Carina-The Gap samples were divided by sex, the following pattern emerged (Table 6.10). Males were somewhat more likely to be high on the knowledge index than females though suburban differences were still to be seen operating quite strongly. Forty-five percent of Carina males were high scorers compared with 39% of females from that suburb, while at The Gap the figures were 52% for males and 47% for females.

TABLE 6.10

RELATIONSHIP BETWEEN SEX AND SCORE ON THE KNOWLEDGE INDEX: CARINA AND THE GAP SAMPLES (percentages)

Knowledge Index	Carina		The Gap	
	Males	Females	Males	Females
Low	29	30	17	21
Medium	27	30	31	32
High	45	39	52	47
	(191)	(299)	(251)	(338)

The effects of age on knowledge about helping services were negligible. Young respondents were no more likely to be high scorers on the knowledge index than those who were older. There were no patterned differences, either, with

respect to where the respondent spent most of his childhood: high scorers on the index were about equally likely to have grown up in a city, provincial town or country area. National origin was important however, though its influence was not clearly discernible because of the small numbers of migrants in the suburban samples. From both suburbs the Australian-born were considerably more likely to be high scorers on the knowledge index than the British migrants but the analysis of the European migrants, who appeared to be high scorers, was hampered by their small numbers.

There is one last issue to be taken up in this chapter. If the knowledge index divides the respondents according to their level of information about various helping services, it will be interesting to look at the relationship between it and the evaluation of the seriousness of psychiatric symptoms and the recognition of mental illness. Are the'knowledgeables' more likely to perceive the seriousness of the symptoms of psychiatric illness? And, are they better able to recognize mental illness in the simulated case-histories than those who have a lower score on the knowledge index? These questions were explored by

means of cross-tabulations of the knowledge index with first, the evaluation of seriousness index (Table 6.11) and second, the recognition of mental illness index (Table 6.12).

TABLE 6.11

RELATIONSHIP BETWEEN SCORES ON THE KNOWLEDGE INDEX AND THE EVALUATION OF SERIOUSNESS INDEX: CARINA AND THE GAP SAMPLES (percentages)

Knowledge Index	Evaluation of Seriousness Index					
	Carina			The Gap		
	High	Medium	Low	High	Medium	Low
Low	26	29	38	22	18	21
Medium	31	29	28	23	36	29
High	44	42	34	55	46	50
	(117)	(272)	(111)	(123)	(344)	(129)

TABLE 6.12

RELATIONSHIP BETWEEN SCORES ON THE KNOWLEDGE INDEX AND THE RECOGNITION OF MENTAL ILLNESS INDEX: CARINA AND THE GAP SAMPLES (percentages)

Knowledge Index	Recognition of Mental Illness Index					
	Carina			The Gap		
	High	Medium	Low	High	Medium	Low
Low	32	29	34	18	21	17
Medium	31	28	34	20	33	37
High	37	43	33	62	46	47
	(78)	(342)	(80)	(91)	(394)	(111)

Generally speaking the results were disappointing. Overall, high scores on the knowledge index were only slightly more likely among the 'psychiatrically sophisticated' respondents - the ones who scored highest on either the evaluation of seriousness index or the recognition scale - but there was really no strong trend to be found in these data. Further, when the cross-tabulations were run again using scores on the knowledge index as the independent variable, there was no relationship between these measures (this is not reported in tabular form). The implications of this are interesting; knowledge about helping services was not necessarily associated with other kinds of mental hygiene information. For example, respondents who were able to recognize the symptoms of mental disorder or who perceived the seriousness of the behaviour in the case-abstracts did not always know where to find helping services.

The data examined here have highlighted two aspects of an important problem. Specifically, they have focussed attention on the relationship between the recognition and evaluation of symptoms and knowledge about treatment facilities. Cross-tabulation of the knowledge index with the evaluation and recognition scales revealed that some sample members were knowledgeable about both the identification

of mental illness and where to find help, while the knowledge of others interestingly enough, was confined to only one of these matters. The important questions to be pursued in future research concern the interplay between these two aspects of knowledge of the help-seeking process - for example, is information about helping services learned in the same way, perhaps via the mass media, as other kinds of mental health information such as the recognition of psychiatric disorder? Or, is the knowledge of members of the community about facilities for help to be understood in the wider context of information about socio-political and administrative institutions? In a more general way, the data emphasize the essentially problematical nature of obtaining treatment by making it clear that even if people are able to recognize the signs of mental illness and they decide to act on them, it is by no means certain that they will know where to turn for help.

SUMMARY AND CONCLUSIONS

This has been an important chapter in both a theoretical and a practical sense. Despite the methodological limitations of the Carina-The Gap study, it is abundantly clear from the data that the issue of knowledge about

where to find a psychiatrist and other kinds of help is a crucial one. In their writing and research, sociologists have been concerned to make the point that obtaining treatment depends very much on the perception of the seriousness of symptoms and the recognition of illness. Yet, in the case of both self and other defined illness, whether or not people actually know where to obtain aid is clearly a vital factor in the help-seeking process. But it is one that has largely been ignored by both academics and practitioners alike. There is no mention of knowledge of resources in the two recent landmark studies in medical sociology - the Wadsworth, Butterfield and Blaney study of the perception of physical illness and use of services in London, and the investigation of the quality and delivery of psychiatric services in New York by Kolb and his associates - nor is it mentioned in the vast and comprehensive review of contemporary trends in community mental health by Bindman and Spiegel.[21]

Overall, the level of knowledge about where to find a psychiatrist was quite high among the Carina-The Gap sample members. Indeed, a rather pleasing number, some 70% of the samples from each suburb said they would know where to consult a psychiatrist. As well, when the

respondents were asked to describe specifically how they would locate a psychiatrist, they were able to provide the interviewers with accurate and realistic details of the steps they would take - such as asking their local or family doctor to recommend one.

Much the same picture emerged with respect to information about where to find help in a marital or financial crisis. Though there was a slight tendency for respondents from The Gap to be better informed, approximately 70% of the sample members said they would know where to obtain assistance for a marital or financial emergency. The follow-up questions revealed that the panel had a broad knowledge of the relevant services and facilities for these kinds of problems.

What factors were related to knowledge about where to find a psychiatrist and help for marital and financial difficulties? Analysis of the survey data focussed on the role of socio-economic status and it was clear that knowledge about the various helping facilities was related to social status: respondents high on the socio-economic

ladder were more likely to be knowledgeable than persons of lower social standing in the community. Because they may be uninformed about where to find the appropriate services, blue collar members of the community may have considerable difficulty in obtaining help for their problems - or so the Carina-The Gap data suggest.

There were other important correlates of knowledge about helping resources. National origin, sex and amount of contact with the mentally ill were found to be associated with knowledge about where to seek help. On the other hand, the respondent's age, whether or not they grew up in a rural or urban environment and whether they had ever needed professional help for a problem were all unrelated to information about helping services. The picture was somewhat obscure with regard to the relationship between levels of information and evaluation of the seriousness of symptoms and recognition of mental disorder; respondents who perceived the seriousness of symptoms or who were able to recognize mental illness in the fictitious cases were only slightly more likely to know where to find helping services than other respondents.

To sum up, this chapter has highlighted the importance of knowledge about services as a vital aspect of the process of seeking help; at the same time, it directed attention to the urgent need for future research into the dimensions of community information about facilities and the personal and demographic correlates of such knowledge.

CHAPTER VII

CONCLUDING REMARKS

Many commentators on the state of modern society have noted that the pressures of urban life promote high rates of mental illness and other social pathologies, and it is often said this situation will become worse. A short quote from an American source will indicate the usual line of reasoning although very few put the case as temperately as they do; "(Such) rapid alterations in living patterns, combined with unpredictable technological changes, lead to unstable social environments and a potential for high incidence and prevalence rates of psychosis... we see how social systems of complex societies have an effect on society's participants."[1] Within the stratified and segmented urban social scene, particular groups have been singled out as more vulnerable to stress than others. Sometimes the mobility and status maintenance anxieties of the middle and upper classes receive attention, but most often the circumstances of the 'underclasses' are described as exacerbating the development of mental disorders or other forms of aberrant behaviour.

Mental illness (the subject of this report) is one of the central problems of modern times and a burden which Australia - as an urban industrial society - may be expected to bear heavily. The task in the final chapter is to examine the implications of the present study for future research and to look at some of the practical applications that arise from it. The discussion begins with a brief review of the main findings of the Psychiatric Morbidity Census and the questionnaire Survey of the two Brisbane suburbs. Next, the data are considered in the light of their indications for further Australian research on the topic of social class and mental illness. Finally, some of the practical consequences of the research are explored, specifically, the relevance of the findings for the provision of effective psychiatric services.

THE FINDINGS: A REVIEW

In the very first chapter of this report it was pointed out that, at least at the time the study was contemplated, Australian research on social class and mental illness had yielded a rather confused lot of results. Right from the outset however, it must be stated that this project cannot

be considered an authoritative or conclusive study of mental illness in an Australian context. Several limitations of the research, confined as it was to two suburbs in a single Australian city, restrict the scope of the generalizations which may be made from it. Yet, it would clearly be a mistake to ignore a number of important findings and suggestive leads provided by the systematic enumeration of psychiatric patients in the Census and from the questionnaire Survey of samples of residents from Carina and The Gap. Thus it is easy to agree with Howard Kaplan when he says -

> Although current studies of the extent of mental illness in specific communities (and, it may be added, research on the social aspects of psychiatric illness) may not be extended to estimates for the entire country, they are of interest in their own right since such data are necessary for studies of the relationship between community structure and mental illness as well as for planning for the provision of mental health facilities.[2]

In the foregoing chapters a variety of data were examined and they formed an interesting picture. Some of the findings were entirely predictable while others were completely unexpected, in some cases contradicting well documented and established overseas evidence. Rather

than presenting a detailed catalogue of the findings - for that the reader should consult the chapter summaries - it is intended to review only the main trends in the analysis.

Turning first to the results of the Morbidity Census, the most dramatic finding was the difference in the total number of cases uncovered from the two suburbs in the period of one year. At Carina the predominantly blue collar area, 219 cases were identified, which is more than twice as many as were found at The Gap, mainly a middle class suburb, where there were 105 cases. The significant thing however, was that when the cases were analyzed with respect to the patient's socio-economic status, no relationship was found between class and the amount and type of mental disorder. This is of course completely the opposite of what has been found in overseas research on the association between social status and psychological impairment - for which one American writer described the supporting evidence as "unambiguous and powerful that the lowest social classes have the highest rates of severe psychiatric disorder."[3]

Certainly there are good reasons for caution in accepting the results of the Brisbane study: for instance, the small number of cases involved; the difficulties associated with using occupational rank only, as a measure of status in studies of mental illness; and the number of cases from both suburbs unclassifiable for socio-economic status because of lack of information. However, when the prevalence figures were supplemented by Survey data - replies to the query, "has any member of this household ever needed to seek medical help for a mental or nervous illness?" - much the same picture emerged. Among sample members from Carina and The Gap, socio-economic status was unrelated to personal experiences and contact with mental illness within the respondent's family.

One tentative conclusion from the Morbidity Census is the possibility of the primacy of areal differences in the prevalence of mental illness and the lack of direct influence of socio-economic standing. The important thing is the Carina-The Gap data should alert Australian scholars to the fact that social class is unlikely to be related to mental disorder in exactly the same ways as it is overseas. Further, it seems as though local researchers will have to pay close attention to the

socio-cultural matrix of mental illness. In other words, they must be prepared to take into account qualitative aspects of the community in which the sick person is located - such as neighbourhood cohesion and community integration, population density, the attraction of deviants to certain social areas, the levels of other social pathologies, and the availability of treatment resources for all groups in the community.

As well as the prevalence data, the Morbidity Census supplied valuable information about the use of psychiatric services made by residents from the two suburbs. Indeed this was one of the most important findings of the whole project, although the interactive effects of social status and suburban residence on treatment could not be completely untangled because of the small number of cases. However, the influence of socio-economic status was clearly visible upon the patterns of use of private psychiatrists (for example, this was usually confined to white collar patients), general practitioners, and public medical and psychiatric hospitals. From these data, it was abundantly clear that Australian scholars would find future investigations of the relationship between social status and psychiatric treatment a particularly rewarding endeavour.

The results of the questionnaire Survey shed more than a little light on some aspects of the social process of becoming a psychiatric patient. Three interrelated parts of the process were examined; the evaluation of the seriousness of symptoms of psychiatric illness, recognition of mental illness, and knowledge about where to find a psychiatrist.

The disturbing fact about the evaluation of seriousness and the recognition of illness was the low level of 'psychiatric sophistication' of sample members from both suburbs. When presented with simulated case-histories, very few respondents - from either Carina or The Gap - perceived the seriousness of the behaviours or identified the illnesses portrayed in the vignettes. Evaluation of seriousness and recognition of illness was virtually confined to behaviour in the cases characterized by overtones of violence (paranoid schizophrenia) or disruption of role-relations (alcoholism). It was a matter for some concern too, that the less 'spectacular' but none the less grave illnesses such as endogenous depression (a high suicide risk) and simple schizophrenia were rarely judged to be serious or identified as an illness.

Socio-economic status was related to the recognition of mental illness in the fictitious cases. When the data were analyzed by occupation and educational rank, respondents higher up the social scale were more likely than those below them to identify mental illness in the vignettes. On the other hand, the evaluation of seriousness was only weakly influenced by educational level and not at all by occupational rank.

Knowledge about where to find psychiatric treatment - and help for marital and financial problems - was surprisingly and pleasingly high among sample members. The majority of respondents from both suburbs claimed they knew where to locate a psychiatrist and, when pressed for details, they were able to specify accurately where they would take their troubles.

When the data were analyzed by socio-economic status, there were clear-cut differences among the samples according to their occupational and educational rank. Professional and managerial workers and the tertiary educated were much more likely than blue collar workers and those with only primary schooling to know where to find a psychiatrist. But it was a comparative affair,

because more than half of the low status respondents knew where to seek the services of a psychiatrist. The situation was much the same for knowledge about where to obtain marriage guidance and financial assistance.

This then, is a brief sketch of the main findings, now it is time to look at the implications of these data, beginning with their relevance for future research.

DIRECTIONS FOR FUTURE AUSTRALIAN RESEARCH

First of all, there are some general points raised by the Psychiatric Census and the Survey. This project has demonstrated the advantages of carrying-out concurrent studies of the prevalence of mental illness and the social processes involved in becoming a patient. In a general way, when the prevalence figures were considered together with the data on the evaluation of symptoms and the recognition of illness, a fuller, comparative picture emerged of the two suburbs. Specifically, the data on class differences in knowledge about where to find a psychiatrist raised the possibility that socio-economic differences existed in the 'true' or endemic prevalence

of mental illness (as Hollingshead and Redlich call it),[4] but these differences were 'masked' by an intervening phenomenon - knowledge about where to find help. Future investigators then, would be well advised to combine studies of the rates of mental illness with research into social factors and community dynamics.

This has raised the issue that to gain a total picture of mental health and illness in Australia, it will be necessary to supplement prevalence data - of cases already in treatment - with 'true' prevalence studies of illness in the population, by using symptom rating scales and interview assessments.

There are two other general points to be made. The first one may be stated in the form of an exhortation to researchers to conduct further surveys on representative samples and in different communities to obtain an overall Australian picture. Cross-community comparisons (of psychiatric disorders, patterns of treatment, etc.) will be imperative then, before generalizations may be applied to the wider society. Second, an obvious implication from this study is that larger samples are required to enable

more sophisticated multi-variate analyses and more refined cross-tabulations than were possible on the Carina-The Gap data.

On a more specific note, there are some detailed suggestions for Australian research on social class and mental illness. One of the first issues confronting a researcher on this subject is the definition of social class to be used. Although there are several sound pragmatic reasons for taking a 'nominalist' stance (for example, ease of use in analysis), it must be recognized this approach has its limitations, especially for studies of mental illness. Two main difficulties are as follows: occupation by itself is inadequate because, as Krupinski and Stoller[5] have noted, occupational rank may reflect the influence of a psychiatric illness (in the case of the downward mobility of the schizophrenic); and, levels of education and occupation may be rather poor indices of class, which requires more sophisticated measures such as style of life, consumption patterns and work satisfaction.

The next point concerns a set of problems under the general rubric Hollingshead and Redlich labelled 'the phenomenology of class and mental illness.'[6] Because of

the lack of relevant Australian research, these problems are probably better formulated in a series of questions. For example, does being a blue collar worker have special significance and meaning for the development of certain kinds of symptoms and illnesses and not others? A tentative 'no' is possible to that question from the results of the Morbidity Census. In what way does class position influence the recognition of particular behaviours and not others as symptoms of mental disorder and therefore, to be acted upon? Detailed studies are needed then, of the relationship between the psychology or rather the social psychology of class, and states of mental health and illness.

Following from the point above and expanding it a little, reflection on the analysis of the simulated case-histories leads to the conclusion that very little is known about the common-sense perceptions and understanding of mental illness - despite some twenty years of mental health research by sociologists, psychologists, and psychiatrists. Answers are wanted for the following kinds of questions; what do people understand by the term 'mental illness'? What do they mean by the phrase 'having a nervous breakdown'?

What is the relationship between mental illness and nervous breakdown in the language of the common man? The Survey data at least hints that when the label 'mental illness' is used, it refers in a narrow frame of reference, to behaviour associated with physical violence and unpredictability. In-depth studies are needed reproducing fully community member's own views of these concepts and their relation to actions.

Some remarks are in order about the use of simulated cases of mental illness in future research. This study focussed on two aspects of responses to the vignettes. Perception of the seriousness of the behaviours was judged by responses to the question 'how serious do you think this is'? Yet it is not quite clear what respondents meant by seriousness. Did their judgements of 'not serious' reflect tolerance of abnormal behaviour or simply ignorance of psychiatric matters? This was not readily apparent from the data at hand, and further studies (using the case-abstracts) would be well advised to seek clarification on this point. Replies to the second query about the cases, 'would you say Mr. A (etc.) has some kind

of a mental illness or not'?, while they provided very helpful information, would be made even more meaningful if community member's subjective (personal) understanding of the term 'mental illness' was known. Thus it is worth reaffirming the point made earlier, that researchers must very soon come to grips with laymen's common-sense usage of words like 'mental illness', 'nervous breakdown' and so on.

One criticism of the vignettes is they ignore the fact that judgements about abnormal behaviour occur in a social context. For example, are there some occasions when behaviour like that of the paranoid schizophrenic case may be excused or ignored, perhaps because of situational contingencies? Scheff has argued that much deviant behaviour is ignored or denied, rather than labelled as mental illness and acted upon.[7] What is needed then, is an exploration of the effects of different social interactional contexts on judgements about the cases; to that end the behaviours should be 'situated' with various contextual information and further interviews carried out. For example, the cases should be presented to respondents with systematic variations in the personal details of the subject (class, age, sex) and in the

interactional contexts (vocational, familial and leisure activites).

A last point about the cases is that they vary somewhat in the amount of diagnostic detail revealed about each of them - the paranoid schizophrenic case is quite rich in diagnostic content, compared with the case of the obsessional neurosis or the drug dependence. Systematic assessment of the possible effects of this upon judgements is required if the vignettes are to be employed in future research.

An unavoidable conclusion from this study is that mental health professionals know very little about the sources from which members of the community obtain their knowledge, attitudes and opinions about mental illness. Is contact with the mentally disturbed the most important source of information? Of recent times there has been a noticeable growth in the activities of the mental hygiene movement in Australia - through educational programmes on television and radio, as well as newspaper and magazine advice columns. Do mental health informational campaigns play the main part in the dissemination of information and

formation of attitudes and, if so, are they received and absorbed by all sections of the population? There are no ready answers to these queries, in fact it is unlikely if they are even a comprehensive list of questions. One of the first priorities on the agenda then, is local research into the sources of information and opinions about mental health and illness and, specifically, studies of the effects of educational campaigns and programmes with a mental health content.

SOME PRACTICAL CONSIDERATIONS

A number of the themes raised in this report have immediate relevance for the practice of psychiatry. To start with, the areal differences in the prevalence of mental illness suggest an interesting question: do some suburbs have special psychiatric problems? Data from the Psychiatric Census highlighted the problems of one suburb, Carina, with a distinctive population - deserted wives, aged and invalid pensioners - perhaps attracted by the low-cost housing or other features of the socio-cultural environment. Furthermore, will social areas burdened by disproportionately high rates of mental illness, also be characterized by high levels of other kinds of social pathology (such as suicide, crime, delinquency and

vandalism)? A preliminary analysis of the Carina-The Gap data indicates this will be a profitable, though disturbing line of enquiry in the future, and this impression is strengthened by the findings of a recent study in the Sydney metropolitan area -

> ...there exists non-random patterns in the geographical distribution of referral rates (of various deviant behaviours)... the most interesting pattern is the positive correlation of referral rates across suburban areas. This indicates that the different forms of social deviance investigated here tend to vary similarly in the frequency of their occurrence throughout the municipality.[8]

Australian scholars will be well advised to look carefully and closely at the possibility that certain suburbs carry a disproportionate amount of social pathology and hardship; at any rate, one useful suggestion is that rates of mental illness may be fully and fruitfully understood in the context of the interrelation of various social problems - crime, delinquency, suicide, wife desertion and poverty.

The second point, and one for serious concern, is the lack of services within either suburb to cope with any of the forms of personal and social disorganization found

there. At both Carina and The Gap, the only professional services available - except pastoral counselling - are the local medical general practitioners.[9] Are local, centralized services the answer to the problems of modern suburban life? It seems obvious that some sections of the community will be better able to use localized facilities (for psychiatric and other kinds of problems) than services placed in cities, some distance away from the residential areas of the suburb: for example, the special circumstances of a deserted wife with four children or the elderly and infirm may deter them from seeking help at clinics situated in the city-centre, because of gross inconvenience, time and cost. Serious considerations should be given to the possibility of localizing services within the community, and this would seem particularly feasible in areas which have demonstrated (or perhaps may be predicted to have) high rates of social pathology. Bryson and Thompson's experiences in a Melbourne working class suburb (with existing psychiatric services) indicates that this would be a good idea, although their warnings about the establishment of a general family welfare agency should be heeded.

> its approach would need to be innovative, as it is likely that non-professional workers who are internal caretakers would operate more effectively with the local families than professionals who often have difficulty communicating with working-class clients. Such an agency would also need to retain maximum flexibility so that it could provide a variety of services in response to changing needs.[10]

The concept of a community welfare centre offering a range of facilities has much to commend it, and it is interesting to note the conclusions of Hetzel, Krupinski and Stoller on this subject:

> As there is a clear relation between physical and psychological disorders and social and family problems, there is a need for a total integrated approach to family welfare. This could be met by the creation of local community health and social centres, which could provide a wide range of services required by the family.[11]

There is considerable merit in such a proposal and so there is too, in Burnheim's idea of a 'treatment catchment area system' at the community level; "the psychiatric centre is one element, or sub-system, in a complex system of inter-related service and control agencies that comprise the overall network of resources for mental health in our catchment area."[12] Among the 'elements or sub-systems',

Burnheim includes: various other facilities such as public and private hospitals; a range of statutory bodies including welfare, educational and law enforcement agencies; individual care-giving agents such as general practitioners, private psychiatrists and other health and welfare workers; and, informal community resources such as the clergy, teachers, fraternal groups and neighbourhood people with a counselling potential.[13]

Both proposals outlined here have the value of recognizing that adequate mental health facilities should be intimately related to the community which they are designed to serve, and that a 'total' integrated service must be offered - for psychiatric, socio-emotional and financial problems.

Finally, it must be said that there is an urgent need for educational and instructive programmes to disseminate mental health information: Hetzel, Krupinski and Stoller pointed out that -

> Both the public and general medical practitioners need to be more aware of the prevalence of psychological disorders and neurotic symptoms and their relation to physical diseases and complaints. There is, in other words, a need for more mental health education at all levels.[14]

One of the alarming aspects of the responses to the simulated case-histories was the appallingly low perception of the seriousness of psychiatric symptoms and the low recognition of mental illness. The Carina-The Gap data suggest that few people would be capable of identifying the symptoms and signs of mental disorder in either their own or other's behaviour - the implication is that early treatment, with all of its benefits, is unlikely to be sought by many. Perhaps this problem could be overcome by informational campaigns to promote community sensitivity to the frequency, effects, and particularly, to the manifestations of mental illness. It is possible of course, that if such mental hygiene education programmes were sponsored by highly visible, local, neighbourhood-based agencies such as a community welfare centre, they may be more successful in spreading information and changing attitudes than the campaigns of centralized, bureaucratized government agencies in the city-centres.

Also, it is worth sounding a warning note that mental health educators must learn the lessons from overseas experience if they are to be successful: social class factors may intrude because blue collar people may not be exposed to mass media messages on mental health topics; and, as Kingsley Davis and others have warned, the mental hygiene literature often reflects a middle class value bias, that removes it from the concerns and relevance of the blue collar world.[15]

Writing about the role of the sociologist in the making of social policy, Freeman and Sherwood have put forward the view that, "the social scientist should direct his work toward the solution of contemporary social problems and that the amelioration of the ills of society should be a guiding force in the work of social researchers."[16] As a last word, it is hoped this thesis has been more than an academic exercise: it would be pleasing if what was said here demonstrated that sociology has something serious to say and something concrete to offer. For mental illness is, in terms of the size of the problem and the extent of the disability and suffering it causes, one of the most pressing problems of modern times.

APPENDIX 1

PSYCHIATRIC MORBIDITY CENSUS PRO-FORMA QUESTIONNAIRE

Please tick where appropriate below.

IDENTIFICATION CODE . . . . . .

. . . . . .

SEX Male/Female AGE. . . . DATE OF BIRTH . . . .

CIVIL STATUS: Single/Married/Widowed/Div./Sep./Defacto

OCCUPATION: . . . . . .
(If full-time household duties, give occupation of spouse)

LENGTH OF RESIDENCE IN AREA:
- Less than 6 months
- 6 months - 2 years
- 2 - 5 years
- 10+ years

DIAGNOSIS

FUNCTIONAL PSYCHOSIS -
- Schizophrenia
- Manic-depressive psychosis
- Other functional psychosis

ORGANIC PSYCHOSIS -
- Dementia associated with old age
- Psychosis due to drugs/alcohol
- Psychosis due to infection/trauma
- Psychosis associated with metabolic or endocrine disorder
- Puerperal psychosis
- Psychosis associated with epilepsy
- Other organic psychosis (Specify if possible)

PSYCHONEUROSIS -
- Anxiety State
- Neurotic depressive reaction
- Hysterical reaction
- Obsessional neurosis
- Phobic states
- Other neurotic illnesses

PERSONALITY/CHARACTER DISORDER - Psychopathic personality
Sexual deviance
Drug/Alcohol Dependence
Other

CHILDHOOD BEHAVIOURAL DISORDERS

SUBNORMALITY/SEVERE SUBNORMALITY

ROAD TRAFFIC ACCIDENTS

Has your patient suffered from injuries due to a road traffic accident (in past 10 years)?

YES/NO

Approximate Date of Accident. . . . . Nature of injury. . . .

. . . . . .

Was patient the Driver Passenger Pedestrian

Was patient in an Automobile Motor-bicycle Bicycle

Pedestrian Other form of transport

APPENDIX 2

QUESTIONNAIRE USED IN PSYCHIATRIC MORBIDITY CENSUS

CONFIDENTIAL

COMMUNITY HEALTH PROJECT

University of Queensland:-
Department of Social and Preventive Medicine
Department of Government

INSTRUCTIONS. Ask for the youngest man aged 21 or over who lives in the house. If there are no men at home, ask for the youngest woman aged 21 or over. Vary this in accordance with the instructions in the Interviewers' Manual.

OFFICE USE ONLY
Col.1:Deck Ident.
Cols.2-4:R Ident.
Col.5:Area Ident.
Col.6:C.D. Ident.

SAY: Good (morning etc.) I'm (NAME) from the University of Queensland. As you may have heard, we are conducting a study of Community Health and Social Problems in this area. I wonder if you could spare a few minutes to answer some questions and give your opinions. All information obtained is kept strictly confidential and is used only in Computer Analysis. No names are required.

IF R IS DOUBTFUL, EXPLAIN FURTHER (SEE MANUAL)

1. Firstly, could you tell me how long you have been living in this neighbourhood? (RECORD EXACT LENGTH OF TIME, THEN CIRCLE CATEGORY)

(IF R IS UNSURE, READ OUT CATEGORIES)

	Col.7
Less than 12 months.....	2
1-2 years.....	3
3-5 years.....	4
6-10 years.....	5
Over 10 years.....	6
Can't remember.....	2

2. Could you tell me how many times the family has shifted during the past ten years? (RECORD EXACT NUMBER, THEN CIRCLE CATEGORY)

	Col.8
Not at all.....	2
Once.....	3
Twice.....	4
Three times.....	5
More than three times....	6
Don't know.....	1

2a. Do you like living in this neighbourhood? Would you say you are very satisfied, satisfied, dissatisfied, very dissatisfied - or would you say you are neither satisfied nor dissatisfied?

Col.9

Very satisfied.....2
Satisfied.....3
Neither satisfied nor dissatisfied.....4
Dissatisfied.....5
Very dissatisfied.....6
Don't know.....1

3. Would you say the people living in this neighbourhood keep out of trouble with the law, or are there some people who regularly get in trouble with the law?

Col.10

Keep out of trouble.....2
Some get in trouble.....3
Don't know.....1

4. Have you ever had to call the police about anyone in this neighbourhood?

Col.11

Yes.....2
No.....3
Can't remember, D.K.....1

4a. IF "YES" TO QUESTION 4, ASK: When was the last time you had to call them about someone in this neighbourhood? (RECORD EXACT ANSWER, THEN CIRCLE APPROPRIATE CATEGORY)

Col.12

In the last 12 months.....2
1 - 2 years ago.....3
3 - 5 years ago.....4
6 - 10 years ago.....5
More than 10 years ago....6
Can't remember, D.K.....1

4b. IF "YES" TO QUESTION 4, ASK: What was that about? (RECORD ANSWER IN FULL)

Col.13

_____

_____

_____

Cant remember, D.K..1

5. (Now) I'd like to describe a certain type of person, and ask you a few questions about him. (SHOW CARD 1, AND READ ALOUD).

Mr. A is a married man of 35 who has a responsible clerical job. For some months now he has felt compelled to repeatedly wash his hands, although he realizes that he is doing this to excess. He has washed his hands so much that they are sore, and the family complain that they can't get into the bathroom.

5a. How serious do you think this is?

	Col.14
Very serious	2
Quite serious	3
Not very serious	4
Not at all serious	5
Don't know, not sure	1

5b. Do you think Mr. A could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all? (IF MORE THAN ONE ANSWER, SAY:) Which one would help him most?

	Col.15
A clergyman	2
A close relative or family friend	3
His local or family doctor	4
A psychiatrist,	5
A social worker	6
somebody else (SPECIFY) _____	7
Mr. A does not need any help	8
Don't know	1

5c. Would you say that Mr. A has some kind of mental illness or not?

	Col.16
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

5d. IF "YES" OR "POSSIBLY" TO 5c, ASK:
Do you think this illness can be cured:

	Col.17
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

6. Now I'd like to describe another type of person. (SHOW CARD 3, AND READ ALOUD) Mr. B is a 40 year old clerk who lives by himself in a flat. He has always been rather shy. Over the past few months, his employer has noticed that Mr. B has become very quiet and suspicious. He talks of a plot of some kind and says the police are watching him. A couple of times he has punched people who didn't even know him, because he thought that they were plotting against him. And he often sits idle at work, staring in front of him.

6a. How serious do you think this is?

	Col.18
Very serious	2
Quite serious	3
Not very serious	4
Not at all serious	5
Don't know, not sure	1

6b. Do you think Mr. B could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all? (IF MORE THAN ONE ANSWER, SAY:) Which one would help him most?

	Col.19
A clergyman	2
A close relative or family friend	3
His local or family doctor	4
A psychiatrist	5
A social worker	6
Somebody else (SPECIFY) _____	7
Mr. A does not need any help	8
Don't know	1

6c. Would you say that Mr. B has some kind of mental illness or not?

	Col.20
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

6d. IF "YES" OR "POSSIBLY" TO 6c, ASK: Do you think this illness can be cured?

	Col.21
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

7. (SHOW CARD 4, AND READ ALOUD)
Mr. C is a middle aged business man. He has always needed sleeping tablets, but lately he takes 3 or 4 to get a good night's sleep and he takes a few during the day "to steady his nerves".

7a. How serious do you think this is?

	Col.22
Very serious	2
Quite serious	3
Not very serious	4
Not at all serious	5
Don't know not sure	1

7b. Do you think Mr. C could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all? (IF MORE THAN ONE ANSWER, SAY:) Which one would help him most?

	Col.23
A clergyman	2
A close relative or family friend	3
His local or family doctor	4
A psychiatrist	5
A social worker	6
Somebody else (SPECIFY) _____	7
Mr. C does not need any help	8
Don't know	1

7c. Would you say that Mr. C has some kind of mental illness or not?

	Col.24
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

7d. IF "YES" OR "POSSIBLY" TO 7c, ASK: Do you think this illness can be cured?

	Col.25
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

8. (SHOW CARD 5 AND READ ALOUD)
Mr. D is a widower, aged 81 years, who have lived with his married son and his family for several years. Recently, he has been going for walks on his own and getting lost, and the police have brought him home. His family realize that sometimes he thinks he is living in the past, and doesn't remember things at all well.

8a. How serious do you think this is?

Col.26

Very serious.....2
Quite serious.....3
Not very serious....4
Not at all serious..5
Don't know, not sure6

8b. Do you think Mr. D could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all? (IF MORE THAN ONE ANSWER, SAY:) Which one would help him most?

Col.27

A clergyman.....2
A close relative or family friend.....3
His local or family doctor.....4
A psychiatrist.....5
A social worker.....6
Somebody else (SPECIFY)_____.7
Mr. D does not need any help.....8
Don't know.....1

8c. Would you say that Mr. D has some kind of mental illness or not?

Col.28

Yes.....2
No.....3
Possibly, perhaps...4
Don't know.....1

8d. IF "YES" OR "POSSIBLY" TO 8c, ASK: Do you think this illness can be cured?

Col.29

Yes.....2
No.....3
Possibly, perhaps...4
Don't know.....1

9. (SHOW CARD 6 AND READ ALOUD)
Mr. E is a single man in his twenties, living with his parents. He never holds a job for long, and doesn't seem to worry about looking for work. He is a very quiet person who doesn't talk much to anyone, even his family. He acts like he is afraid of people, especially young girls his own age. He doesn't go out with anyone and when people come to visit he stays in his room until they go. He prefers to stay by himself and daydream, or listen to the radio in his room.

9a. How serious do you think this is?

	Col.30
Very serious	2
Quite serious	3
Not very serious	4
Not at all serious	5
Don't know, not sure	6

9b. Do you think Mr. E could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all? (IF MORE THAN ONE ANSWER, SAY:) Which one would help him most?

	Col.31
A clergyman	2
A close relative or family friend	3
His local or family doctor	4
A psychiatrist	5
A social worker	6
Somebody else (SPECIFY) _____	7
Mr. E does not need any help	8
Don't know	1

9c. Would you say that Mr. E has some kind of mental illness or not?

	Col.32
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

9d. IF "YES" OR "POSSIBLY" TO 9c, ASK: Do you think this illness can be cured?

	Col.33
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

10. (SHOW CARD 7 AND READ ALOUD)
Mr. F is 50 years old. He has always been happily married and has a healthy, grown up family. For many years he has been active in church work but lately is very upset because he feels he has lost his Faith. He has not slept well for many weeks because he is so unhappy. He eats very little and is losing weight. He blames himself for his present misery and insists he is a worthless man.

10a. How serious do you think this is?

	Col.34
Very serious	2
Quite serious	3
Not very serious	4
Not at all serious	5
Don't know, not sure	1

10b. Do you think Mr. F could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all?

	Col.35
A clergyman	2
A close relative or family friend	3
His local or family doctor	4
A psychiatrist	5
A social worker	6
Somebody else (SPECIFY) _____	7
Mr. F does not need any help	8
Don't know	1

10c. Would you say that Mr. F has some kind of mental illness or not?

	Col.36
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

10d. IF "YES" OR "POSSIBLY" TO 10c, ASK: Do you think this illness can be cured?

	Col.37
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

11. (SHOW CARD 8 AND READ ALOUD)
Mr. G has a good job and is doing quite well at it. Most of the time he gets along all right with people, but he loses his temper if things go wrong or if people criticize him. He worries a lot about little things and he seems to be moody and unhappy all the time. Everything is going along well for him, but he can't sleep at night, brooding about the past and worrying about things that might go wrong.

11a. How serious do you think this is?

	Col.38
Very serious	2
Quite serious	3
Not very serious	4
Not at all serious	5
Don't know, not sure	6

11b. Do you think Mr. G could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all?

	Col.39
A clergyman	2
A close relative or family friend	3
His local or family doctor	4
A psychiatrist	5
A social worker	6
Somebody else (SPECIFY) _____	7
Mr. G does not need any help	8
Don't know	1

11c. Would you say that Mr. G has some kind of mental illness or not?

	Col.40
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

11d. IF "YES" OR "POSSIBLY" TO 11c, ASK: Do you think this illness can be cured?

	Col.41
Yes	2
No	3
Possibly, perhaps	4
Don't know	1

12. (SHOW CARD 9 AND READ ALOUD)
Mr. H is 40 years old. He never seems to be able to hold a job for very long because he drinks so much. Whenever he has any money he goes on a "bender", and doesn't seem to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

12a. How serious do you think this is?

Col.41

Very serious.....2
Quite serious.....3
Not very serious....4
Not at all serious..5
Don't know, not sure6

12b. Do you think Mr. H could be helped by any one of these, (SHOW CARD 2) or don't you think he needs any help at all? (IF MORE THAN ONE ANSWER, SAY:) Which one would help him most?

Col.42

A clergyman.....2
A close relative or family friend.....3
His local or family doctor.....4
A psychiatrist.....5
A social worker.....6
Somebody else (SPECIFY)_____7
Mr. H does not need any help.....8
Don't know.....1

12c. Would you say that Mr. H has some kind of mental illness or not?

Col.43

Yes.....2
No.....3
Possibly, perhaps...4
Don't know.....1

12d. IF "YES" OR "POSSIBLY" TO 12c, ASK: Do you think this illness can be cured?

Col.44

Yes.....2
No.....3
Possibly, perhaps...4
Don't know.....1

13. Could you tell me some thing about this household? How many people are living here? (RECORD EXACT ANSWER)

Col.45

_____

13a. Could you tell me a little about the people who live here? Could you tell me the age, sex, and relationship to the head of the household of each person living here? (RECORD H/H FIRST. MARK RESPONDENT WITH AN "R" BEFORE AGE)

	AGE	SEX	RELATIONSHIP TO H/H	Cols.46-75
i)	___	___	_____	
ii)	___	___	_____	
iii)	___	___	_____	
iv)	___	___	_____	
v)	___	___	_____	
vi)	___	___	_____	
vii)	___	___	_____	
viii)	___	___	_____	
ix)	___	___	_____	
x)	___	___	_____	

OFFICE USE ONLY

Col.1: Deck Ident.(2)
Cols.2-4: R. Ident.
Col.5: Area Ident.
Col.6: C.D. Ident.

14a. Have you ever known anyone who was in hospital because of mental or nervous illness?

Col.7
Yes.....2
No.....3
Don't know, can't remember1

14b. IF "YES" TO QUESTION 14a, ASK: Was this a relative, close friend, or someone you didn't know very well?

Col.8
Self.....2
Relative.....3
Close friend...4
Acquaintance...5
Can't remember.1

15a. Have you ever known anyone who has sought help from a doctor or psychiatrist for mental or nervous illness?

Col.9
Yes.....2
No.....3
Don't know, can't remember.1

15b. IF "YES" TO QUESTION 15a, ASK: Was this a relative, close friend, or someone you didn't know very well?

Col.10

Self.....2
Relative.....3
Close friend.....4
Acquaintance.....5
Can't remember.....1

16. Has any member of this household ever needed to seek medical help for a mental or nervous illness?

Col.11

Yes.....2
No.....3
Don't know.....1

16a. IF "YES" TO QUESTION 16, ASK: Could you tell me who - which one of the people you mentioned earlier? (RECORD STATUS AND NUMBER FROM QUESTION 13a, PAGE 9).

Col.12

_____

Don't know.....1

16b. What sort of help did he/she seek? Was it from a local or family doctor, or from a private psychiatrist, or from a hospital outpatient clinic, or as a patient in a hospital?

Col.13

Local or family doctor.....2
Other (psychiatrist) help.....3
Both.....4
Other (SPECIFY) _____ 5
Don't know, can't remember.....1

16c. Did this take place while you were living in this neighbourhood, or before you came here?

Col.14

Before coming to district, has not recurred here.....2
Before coming to district, has recurred here.....3
Occurred for first time while in this district....4
Can't remember.....1

17. Has any member of this household suffered from:-

	Yes	No	D.K.	
a. persistent headaches?	2	3	1	Col.15
b. Irritability?	2	3	1	Col.16
c. Nervousness?	2	3	1	Col.17
d. Tension?	2	3	1	Col.18

Don't know.....1

18. Do any people here take regular doses of:-

	Yes	No	D.K.	
a. Sleeping tablets?	2	3	1	Col.19
b. Headache tablets?	2	3	1	Col.20
c. Other "nerve" tablets?	2	3	1	Col.21
d. What kind of "nerve" tablets? _____				Col.22

18a. Could you tell me if any members of this household are heavy drinkers?

Col.23

Yes, one.....2
Yes, two or more.....3
No, none.....4
Don't know.....1

18b. IF "YES" TO QUESTION 18a, ASK: Could you tell me who? (NOTE STATUS AND NUMBER FROM QUESTION 13a, PAGE 9)

Cols.24-25

_____

_____

Don't know.....1

18c. IF "YES" TO QUESTION 18a, ASK: Why do you say that he/she/they is a heavy drinker? (RECORD ANSWER IN FULL)

Col.26

_____

_____

Don't know.....1

Problems often come up in life. Sometimes they're personal problems - people are very unhappy or nervous and irritable all the time. Sometimes they are in a marriage - a husband and wife just can't get along with each other, or it is a personal difficulty with a child or job. When people have problems like that, they often go somewhere for help.

19a. How about you - have you ever wanted advice or had a problem for which professional help (such as a psychiatrist or a social worker) would have been useful?

Col.27

Yes.....2
No.....3
Can't remember....1

19b. IF"YES" TO QUESTION 19a, ASK: What did you do? Did you seek (professional) help?

Col.28

Yes.....2
No.....3
Can't remember....1

19c. IF "NO" TO QUESTION 19b, ASK: Why do you suppose that you didn't go for help? (Advice?)

Col.29

Did not know where to go.....2
Ashamed of what friends/ relatives would think.....3
Prefer to solve it by myself....4
Some other reason (SPECIFY) _____ 5
Don't know, not sure.....1

19d. IF "YES" TO QUESTION 19a, ASK: What was the nature of the problem?

Cols.30-31

Financial problem.....2
Personal, emotional problem.....3
Marital difficulty.....4
(Respondent's) children.....5
Other problem (SPECIFY) _____ 6
Don't know.....1

19e. IF "YES" TO QUESTION 19b, ASK: Where did you go for help? (DO NOT READ OUT ALTERNATIVES)

Cols.32-33

Clergyman.....2
Local or family doctor.....3
Doctor (specialist or other)....4
Psychiatrist (private practice).5
Psychiatrist (clinic, hospital, mental hospital)....6
Family or social welfare agency.7
Marriage guidance clinic.....8
Child guidance clinic.....9
Other (SPECIFY) _____ 10
Don't know, can't remember.....1

19f. IF "YES" TO QUESTION 19b, ASK: Were you helped with the problem?

	Col.34
Yes (unqualified)	2
Yes (qualified)	3
No	4
Perhaps, depends	5
Don't know	1

19g. IF "NO" TO QUESTION 19a, ASK: Do you think you could ever have a personal problem or difficulty that got so bad that you might want to go somewhere for advice or help - or do you think you could always handle things like that yourself?

	Col.35
Could certainly imagine needing help	2
Might want to get help	3
Could handle problem by self	4
Would never need help or advice	5
Depends, perhaps	6
Don't know	1

20a. Now, suppose you did have a problem and wanted to talk to a psychiatrist. Would you know where to go to find one?

	Col.36
Yes	2
Not sure, depends	3
No	4
Would never need to see one	5
Don't know	1

20b. IF "YES" TO 20a, OR "NOT SURE", ASK: What would you do? How would you go about finding a psychiatrist?

	Col.37
Ask local or family doctor to recommend one	2
Go to nearest public hospital	3
Local government psychiatric clinics and services (e.g. via phone book)	4
Consult a private psychiatrist directly	5
Ask clergyman to refer one	6
Any other way (SPECIFY) _____	7
Don't know	1

21a. What about a husband and wife having marital difficulties? If they were friends of yours, would you be able to tell them where they could receive help if they asked you?

	Col.38
Yes	2
No	3
Don't know, not sure	1

21b. IF "YES" TO 21a, ASK: Whereabouts could a couple go if they were having problems in their marriage?

	Col.39
Family or local doctors	2
Marriage guidance bureau	3
Psychiatrist	4
Clergyman	5
Family welfare agency	6
To an older relative or wise friend	7
Somewhere else (SPECIFY) _____	8
Don't know	1

22a. Now, imagine you were in financial difficulties. Would you know where to go for help?

	Col.40
Yes	2
No	3
Don't know	1

22b. IF "YES" OR "NOT SURE" TO QUESTION 22a, ASK: Where would you go?

	Col.41
Government Relief Assistance Branch	2
Other Government Welfare Service (e.g. Social Services, Repatriation, Children's Services)	3
Non-government Family and Welfare Agency (SPECIFY) _____	4
Credit Unions, Banks, Money Lenders (SPECIFY) _____	5
Other (SPECIFY) _____	6
Don't know, not sure	1

SAY: Now I'd like to ask you about something slightly different.

23a. Suppose there was some question that you had to take to a government office, for example, a tax question or housing regulation. Do you think you would be given equal treatment? I mean, would you be treated as well as anyone else?

	Col.42
Expect equal treatment	2
Don't expect equal treatment	3
Other (SPECIFY) _____	4
Don't know, not sure	1

23b. If you explained your problem to the officials, what effect would it have? Would they give your problem serious consideration, would they pay only a little attention to it, or would they ignore what you had to say?

	Col.43
Serious consideration	2
A little attention	3
Expect to be ignored	4
Other (SPECIFY) _____	5
Don't know	1

24. Some people say that how people who work for the government treat you depends on "who you are". (People who work for the government, civil servants etc.) Do you think this is true?

	Col.44
Yes	2
No	3
Not sure, depends	4
Don't know	1

RECORD COMMENTS:

SAY: I wonder if you could give me some information about crimes which have happened to you or to members of this household in the last ten years? (or, if R has not lived in the neighbourhood for ten years, since you moved to this neighbourhood?) Record All incidents mentioned, then say: Could you just look through these cards and see if you can think of anything (else) which might have happened to you or any member of the household (in the last ten years)? (RECORD DETAILS OF EACH OFFENCE ON A SEPARATE FORM, THEN CLIP THE FORMS FIRMLY TO THE QUESTIONNAIRE) Cols.45-46
(RECORD THE TOTAL NUMBER OF OFFENCES HERE): _____
(TAKE BACK CARDS WHEN R HAS FINISHED)

INCIDENT FORM: COMPLETE A SEPARATE FORM FOR EACH OFFENCE MENTIONED

1. Could you tell me exactly what happened on that occasion? Cols.8-10

_____

_____

Can't remember, D.K....1

2. To whom did this happen, which member of your household? (RECORD STATUS AND NUMBER FROM Q.13a p.9) Col.11

_____

Can't remember.....1
Against household generally.....2
Against R him/her self.3

3. How long ago did this happen? Col.12

This year (1970).....2
Last year (1969).....3
1965-1968.....4
1961-1964.....5
Can't remember, D.K....1

4. Could you tell me where it took place? Col.13

a. Did it happen in this suburb or somewhere else?

In this suburb.....2
Elsewhere.....3
Can't remember, D.K....1

b. Did it happen in your own home or somewhere else? (RECORD ANSWER IN FULL, THEN CIRCLE CATEGORY) Col.14

_____

In own home.....2
Somewhere else.....3
Can't remember, D.K....1

_____

5. Was this offence reported to the police? Col.15

Yes.....2
No.....3
Can't remember.....1

5a. IF "NO" ASK: Here are some reasons people have often given when they did not notify the police of a crime. Which of these reasons did you consider at all, and which did you not consider? (READ EACH REASON BELOW AND CIRCLE THE APPROPRIATE NUMBER)

	Yes	No	Don't know	Col.No.
1. Did not want to take the time, might mean time spent in court or lost from work.	2	3	1	16
2. Did not want harm or punishment to come to the offender.	2	3	1	17
3. Afraid of reprisals	2	3	1	18
4. Thought it was a private not a criminal matter	2	3	1	19
5. Police couldn't do anything about the matter	2	3	1	20
6. Police wouldn't want to be bothered about such things	2	3	1	21
7. Didn't know how to notify them or that they should be notified	2	3	1	22
8. Too confused or upset to notify them	2	3	1	23
9. Not sure the real offenders would be caught	2	3	1	24
10. Fear of insurance cancellation or increased rates	2	3	1	25

5b. Which of these would you say was the most important reason why you did not notify the police of this incident? (IF NECESSARY, READ REASONS TO WHICH R SAID "YES" IN 5a)

Cols.26-27

RECORD NO. OF REASON GIVEN HERE _____

Can't remember, D.K...1

6. IF "YES" TO QUESTION 5, ASK: What action did the police take?

Col.28

_____

_____

Can't remember, D.K.....1

7. IF "YES" TO QUESTION 5, ASK: Were you (the person involved) satisfied with the way in which the police handled the matter?

Col.29

Yes, satisfied.....2
No, not satisfied....3
Don't know.....1

8. Did you (the person involved) know the person who committed the offence?

Col.30

Yes.....2
No.....3
Can't remember, D.K....1

9. Was the offender from this district (suburb)?

Col.31

Yes.....2
No.....3
Can't remember, D.K....1

10. Could you tell me the extent of the injury, loss or damage to property incurred by the victim? (RECORD IN FULL)

Cols.32-34

_____

_____

Can't remember.....1

SAY: Would you mind giving me a few particulars about yourself? This is just to help in classifying the data for computer analysis.

NOTE SEX OF RESPONDENT

Col.47
Male.....1
Female.....2

25. Would you mind telling me your age?

Col.48
16-21.....1
22-25.....2
26-35.....3
36-45.....4
46-55.....5
56-65.....6
Over 65.....7

OFFICE USE ONLY

RECODE AGE Col.49
16-25.....1
26-45.....2
Over 45.....3

26. Could you tell me your present (or last main) Occupation please? (IF RETIRED, PENSIONER, ETC., PLEASE NOTE PREVIOUS OCCUPATION AS WELL AS PRESENT STATUS. RECORD IN DETAIL WITH GRADING WHERE APPLICABLE.)

Cols.50-51

_____

_____

OFFICE USE ONLY
RECODE OCCUPATION OF R

Col.52
P/M.....1
OWC.....2
MW.....3
O.....4

27. Are you the head of the household? (i.e. Do you have the main source of income).

Col.53
Yes.....1
No.....2

27a. IF "NO" TO Q.3, ASK: What is the present (or last main) occupation of the head of the household? (SEE INSTRUCTIONS FOR Q.2)

Cols.54-55

_____

_____

OFFICE USE ONLY
RECODE OCCUPATION OF H/H

Col.56
P/M.....1
OWC.....2
MW.....3
O.....4

28. Could you tell me the present (or last main) occupation of the head of the household's father? (OBTAIN IN DETAIL AS ABOVE)

Col.57

_____

_____

OFFICE USE ONLY
RECODE OCCUPATION OF H/H FATHER

Col.58
P/M.....1
OWC.....2
MW.....3
O.....4

29. Are you married?

Col.59
Single 1
Married.....2
Divorced.....3
Widowed.....4

30. Could you tell me where you were born?

Col.60
Australia.....1
Great Britain..2
Other Europe...3
Other.....4
(SPECIFY) _____

31a. Where did you spend most of your childhood? In a city, provincial town or in the country?

Col.61
City.....1
Provincial or country town..2
Country area on a farm or property.....3

32. Could you tell me how much education you have had? (WRITE THE ANSWER ON THE LINE PROVIDED, THEN CIRCLE THE NUMBER OPPOSITE THE APPROPRIATE CATEGORY)
RECORD ANSWER HERE: _____

Col.62
Some primary.....1
Completed primary.....2
Some secondary.....3
Completed secondary.....4
Technical.....5
Trade.....6
Some university.....7
Completed university.....8
Other.....9

OFFICE USE ONLY
RECODE EDUCATION R

Col.63
Primary.....1
Secondary.....2
Tertiary.....3

33. IF R IS NOT HEAD OF HOUSEHOLD ASK: Could you tell me the education level of the head of the household?

RECORD ANSWER HERE: _____

	Col.64
Some primary	1
Completed primary	2
Some secondary	3
Completed secondary	4
Technical	5
Trade	6
Some university	7
Completed university	8
Other	9

OFFICE USE ONLY
RECODE EDUCATION H/H

	Col.65
Primary	1
Secondary	2
Tertiary	3

34. Could you tell me how big this house is? How many bedrooms or rooms used for sleeping are there?

(RECORD EXACT NUMBER): _____

35. Would you mind telling me your religion?

	Col.65
Catholic	1
C. of E	2
Presbyterian	3
Methodist	4
No religion	5
Other (SPECIFY)	6

_____

OFFICE USE ONLY
RECODE RELIGION

	Col.67
Catholic	1
C of E	2
Other	3
None	4

35a. Would you describe yourself as a strong church-goer; a moderate church-goer, or don't you go very often?

	Col.68
Strong	1
Moderate	2
Not often	3
Never	4

36. Could you tell me if (the head of the household or spouse), attends any of the following clubs or organizations? How often?

	Regular	Frequent	Never	
H/h:-				
Social clubs (sporting, church, ethnic, etc.)	1	2	3	Col.69
Trade Unions, Professional organizations	1	2	3	Col.70
Spouse:-				
Social clubs, (sporting, church, ethnic, etc.)	1	2	3	Col.71
Trade Unions, Professional organizations etc.	1	2	3	Col.72

37. Does any member of the household own:-

	Yes	No	
A car?	1	2	Col.73
A telephone?	1	2	Col.74
A television?	1	2	Col.75
Do you get the daily papers	1	2	Col.76

38. Do you consider public transport in this area to be adequate for your needs?

Col.77

Yes.....1
No.....2
Don't know.....3

OFFICE USE ONLY
Col.1: Deck Ident.(3)
Cols.2-4: R. Ident.
Col.5: Area Ident.
Col.6: C.D. Ident.

this household lost a parent or parents
.g. death, desertion etc.) before the age
UDING ADULTS IN HOUSEHOLD)

	Col.7	Col.8
No, none	1	1
Yes, h/h	2	2
Yes, spouse	3	3
Yes, someone else	4	4

: the household been involved in a road
lid the accident take place?
:, RECORD MOST SERIOUS) Col.9

Yes, in this suburb.....1
Yes, somewhere else.....2
No.....3
Not sure.....4

TION 14, ASK: How serious were his/her

Col.10

Don't know.....1
Other party injured.....2

41. Do you drive a car? Col.11

Yes.....1
No.....2

42. Do you own, or are you buying, or do you rent this house?

Col.12

Own.....1
Buying, paying off2
Renting.....3

AFTER YOU HAVE COMPLETED THE INTERVIEW, PLEASE FILL OUT THE FOLLOWING TABLES:

Col.13

Dwelling unit is on:-

major traffic artery.....1
side street.....2
open country.....3
other (SPECIFY)...4

Are there any of the following in the immediate neighbourhood.

	Next door or adjoining	Within one block	
Retail store	1	2	Col.14
Hotel or licensed premises	1	2	Col.15
Industrial building or warehouse	1	2	Col.16
School, church or public building	1	2	Col.17
Park land or vacant lot	1	2	Col.18
Other (SPECIFY) _____	1	2	Col.19
_____	1	2	Col.20

Dwelling unit is:-

Col.21

Private house.....1
flat in block of 4 or less.....2
flat in block of more than 4...3
Caravan or trailer.....4
Other (SPECIFY) _____5

ADDRESS OF INTERVIEW: _____

INTERVIEWERS NAME (PRINT): _____ Date: _____

APPENDIX 3

PSYCHIATRIC MORBIDITY CENSUS: ANALYSIS OF PENSIONER AND STUDENT CASES FROM CARINA AND THE GAP

In the course of the analysis of the Psychiatric Morbidity Census data (in Chapter 4) it was found that 22% of the Carina cases and 6% from The Gap were classified as "pensioner or student" (see Table 4.05). It will be useful to undertake a brief analysis of these cases here.

To begin, there were very few students (four from Carina and one from The Gap) and the data on them are reported in Table 1 in relation to their diagnoses and the sources of treatment. There is little that needs to be said about these figures and it is proposed to move on to consider the pensioners in some detail.

TABLE 1

STUDENT CASES* FROM CARINA AND THE GAP BY DIAGNOSIS AND TREATMENT SOURCE

Diagnosis			Treatment Source		
Diagnosis	Carina	The Gap	Agency	Carina	The Gap
Functional Psychosis	1	-	General Public Hospitals	1	-
Psycho-Neurosis	2	1	Psychiatric Public Hospitals	2	-
Drug-Alcohol Dependence	1	-	Psychiatric Clinic	2	-
	(4)	(1)		(4)	(1)

*Over 16 years of age

The pensioners, at least those from Carina who will provide the focus of the analysis, are a more substantial group of cases than the students. There were 42 cases classified as pensioner from Carina and 4 from The Gap. The age distribution of these cases appears in Table 2. It is clear that there were a wide range of ages covered by the Carina patients; obviously not all of them will be age pensioners.

TABLE 2

AGE DISTRIBUTION OF PENSIONERS: CARINA AND THE GAP

Age	Carina	The Gap
16 - 20 years	2	1
21 - 25	3	-
26 - 35	4	-
36 - 45	8	-
46 - 55	9	-
56 - 65	2	2
Over 65 years	13	1
N.A.	1	-
	(42)	(4)

The types of pension received by the Carina and The Gap cases are listed in Table 3. The Carina cases fall into two main streams; those who were receiving invalid

TABLE 3

TYPES OF PENSION: CARINA AND THE GAP

Type of Pension	Carina	The Gap
Invalid pension	19	1
T.P.I. (Repatriation Dept.)	2	1
Age Pension	15	2
Deserted-wife, Widows Pension	5	-
No information	1	-
	(42)	(4)

pensions (19 cases) and those on an age pension (15 cases). These figures are interesting, to say the least, and require brief comment. First, it is obvious that the Carina cases, in both number and type, present a vastly different picture than do those from The Gap. Unfortunately, from the information at hand it is not possible to ascertain the reasons for this: for example, it is not clear what part is played by the ready availability of low-cost, low-rental State Housing Commission dwellings, which attract persons such as pensioners, on meagre fixed incomes. Second, it would be instructive to study these, or another larger group of pensioners, in more depth. The kind of question that springs to mind is; what proportion of the invalid

pensioners were disabled by the mental illness that brought them to the notice of psychiatric treatment services during the Morbidity Census? That is, what proportion of the invalid pensioners were chronic cases of mental illness?

What kinds of psychiatric diagnosis were given to the pensioners when they went for treatment (see Table 4 for details)?

TABLE 4

DIAGNOSIS: CARINA AND THE GAP

Diagnosis	Carina	The Gap
Functional Psychosis	9	2
Organic Psychosis	10	-
Psycho-Neurosis	11	2
Personality-Character Disorder	3	-
Drug-Alcohol Dependence	5	-
All others, no information	4	-
	(42)	(4)

Three principal classifications account for the bulk of the Carina pensioners. Nine of the pensioners were classified as functional psychoses and these were mainly cases of schizophrenia. Interestingly, a closer analysis revealed that many of the invalid pensioners were

schizophrenic patients. Ten of the cases were labelled organic psychosis and the majority of these were cases of senile dementia associated with old age. Of the eleven psycho-neuroses, the cases were divided between anxiety states and neurotic depressive reactions.

Finally, in Table 5, it can be seen where the pensioners were located by the Morbidity Census. None of them were found at private psychiatrists, from either suburb. The

TABLE 5

TREATMENT SOURCES: CARINA AND THE GAP

Treatment Agency	Carina	The Gap
Private Psychiatrists	-	-
General Practitioners	20	1
Lowson House	4	3
General Public Hospitals	11	-
Psychiatric Public Hospitals	2	-
Psychiatric Clinic	2	-
Alcoholic Clinic	-	-
Repatriation Hospitals	2	-
No information	1	-
	(42)	(4)

bulk of the Carina cases (20) were located in treatment with general medical practitioners in their suburb. Another substantial group, (11 cases) was found at the two southside public general hospitals.

That completes the analysis of the pensioners and students included in the Morbidity Census. In sum, the limited data examined here have important implications for the mental health professions, by directing attention to the little understood problems of psychiatric pathology in low status areas, especially among the economically disadvantaged groups such as pensioners.

APPENDIX 4

EVALUATION OF SERIOUSNESS INDEX AND RECOGNITION OF MENTAL ILLNESS INDEX: A FURTHER ANALYSIS

In this section of the report it is intended to examine the relationship between scores on the two measures developed in Chapter 5; the evaluation of seriousness index and the recognition of mental illness index. If these scales divided respondents into those who were more or less perceptive about the seriousness of psychiatric symptoms and those who were more or less able to identify the signs of mental abnormality, then it might reasonably be expected that scores on the two scales would be related. For instance, high scorers on the recognition index could also be expected to be high scorers on the evaluation of seriousness index. A cross-correlation of the two measures appears in Table 1.

TABLE 1

RELATIONSHIP BETWEEN SCORES ON THE RECOGNITION OF MENTAL ILLNESS INDEX AND EVALUATION OF SERIOUSNESS INDEX: CARINA AND THE GAP SAMPLES (percentages)

Evaluation of Seriousness Index	Recognition of Mental Illness Index					
	Carina			The Gap		
	High	Medium	Low	High	Medium	Low
High	51	21	8	47	18	9
Medium	40	57	58	46	64	44
Low	9	22	35	7	18	47
	(78)	(342)	(80)	(91)	(394)	(111)

The trend is clear. High scorers on the recognition index were more likely to be high scorers on the evaluation of seriousness index than low scorers on the former measure. At Carina, 51% of high scorers on the recognition index were high scorers on the evaluation index compared with only 8% of the low scorers on the recognition scale; for The Gap, the figures showed that 47% of the high scorers and 9% of the low scorers on the recognition index were high scorers on the evaluation of seriousness measure. The trend was observed again - though not so strongly - when the cross-tabulation was run again using scores on the evaluation of seriousness scale as the independent variable (Table 2).

TABLE 2

CROSS-TABULATION OF EVALUATION OF SERIOUSNESS INDEX AND RECOGNITION OF MENTAL ILLNESS INDEX - USING THE EVALUATION OF SERIOUSNESS INDEX AS THE INDEPENDENT VARIABLE: CARINA AND THE GAP SAMPLES (percentages)

Recognition of Mental Illness Index	Evaluation of Seriousness Index					
	Carina			The Gap		
	High	Medium	Low	High	Medium	Low
High	34	11	6	35	12	5
Medium	61	72	68	57	74	55
Low	5	17	25	8	14	40
	(117)	(272)	(111)	(123)	(344)	(129)

There are two points to be made about these data. First of all, it is apparent that evaluation of the seriousness of psychiatric symptoms and identification of mental abnormality were related, and this lends weight to the evidence of the adequacy of the two measures (in other words, they measure what they purport to). Second, limitations of space in this report and the small numbers in some of the cells precluded further, more refined analysis of the data. It would have been interesting, for example, to look more closely at the personal and demographic characteristics of those respondents who were high scorers on both scales - the 'psychiatrically knowledgeables'- or those (few) persons who scored high on one measure and low on the other.

NOTES AND REFERENCES FOR CHAPTER ONE

1. For example, a recently published Australian book on social problems - perhaps the first of its kind - makes no mention at all of the problem of psychiatric disorder: P.R. Wilson(ed.) Australian Social Issues of the 70's, Sydney: Butterworths; 1972.

2. The extent of psychiatric impairment in modern communities is documented fully in John A. Clausen, "Mental Disorders", in R.K. Merton and R.A. Nisbet (eds.) Contemporary Social Problems, New York: Harcourt, Brace and World; 1966, pp.26-83 and David Mechanic, Mental Health and Social Policy, Englewood Cliffs, New Jersey: Prentice-Hall; 1969, Chapters 1 and 2.

3. Telegraph, 14 September 1971, p.16.

4. This trend is typified by the work of J.F.J. Cade, "The Aetiology of Schizophrenia", The Medical Journal of Australia, (July 28) 1956, pp.135-139; J. Krupinski and A. Stoller, "Occupational Hierarchy of First Admissions to the Victorian Mental Health Department, 1962-1965," The Australian and New Zealand Journal of Sociology, 4(1), 1968, pp.55-63; and W.J. Bruen and B.L. Hennessy, "Patterns in the Geographical Distribution of Referrals to Social and Health Agencies Within a Municipality", Australian Journal of Social Issues, 5(2), 1970, pp.150-159.

5. There is an excellent summary of the literature on social stratification and psychiatric disorders in: F. Riessman et.al.(eds.) Mental Health of the Poor, New York: The Free Press; 1966, and a very recent statement in R. Bastide, The Sociology of Mental Disorder, London: Routledge and Kegan Paul; 1972, Chapter 5.

6. In a very wise and perceptive paper, Raymond Murphy has recognized the pressure in collaborative research (between sociologists and psychiatrists) to ignore differences and to find a common point of departure: "Unresolved issues concerning the most appropriate model or method for conceptualizing the stratification system of the United States, for example, or the heuristic value

6 Cont.

in alternative approaches to the problem of the genesis of neurotic disturbances, tend not to enter extensively into the agenda of planning operations. Such pragmatic concerns as budget, time, a prior agreement to seek what is mutually acceptable to all research participants, plus the impossibility of being a universal scholar, lead to a suspension of problematics." Raymond J. Murphy, "Stratification and Mental Illness: Issues and Strategies for Research", in S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, p.314 (emphasis added).

7. F.C. Redlich and D.X. Freedman, The Theory and Practice of Psychiatry, New York: Basic Books; 1966, p.459.

8. T.S. Szasz, "The Myth of Mental Illness", in T.J. Scheff (ed.) Mental Illness and Social Processes, New York: Harper and Row; 1967, pp.242-254.

9. P. Ford, "Libertarian Psychiatry: an introduction to existential analysis", Anarchy 70, 6(12), 1966, pp.353-374.

10. Szasz, op.cit., pp.245-252.

11. Ford, op.cit., pp.359-360 and pp.365-366.

12. See for example David Ausubel's critique of Szasz and John Wing's criticisms of Laing and Cooper, in T.J. Scheff (ed.) Mental Illness and Social Processes, New York: Harper and Row; 1967.

13. M. Taber et.al., "Disease Ideology and Mental Health Research", Social Problems, 16(3), 1969, pp.349-357.

14. L. Abood, quoted in J.M. Yinger, Toward a Field Theory of Behavior, New York: McGraw-Hill; 1965, p.277.

15. Yinger, ibid., p.277.

16. See the papers (by Rossi, Hobbs, Brown, Dunham and Newbrough) in A.J. Bindman and A.D. Spiegel (eds.) Perspectives in Community Mental Health, Chicago: Aldine; 1969.

17. D.W.G. Timms, The Urban Mosaic: Towards a Theory of Residential Differentiation, Cambridge: Cambridge University Press; 1971, p.22. However, other investigators had drawn attention to the relationship between social status and psychological disorder in earlier research: As the Dohrenwends recognize; "An early instance is Jarvis' finding in 1856, that the "pauper class" in Massachusetts furnished proportionately 64 times as many cases of "insanity" as the "independent class"." B.P. Dohrenwend and B.S. Dohrenwend, Social Status and Psychological Disorder, New York: John Wiley; 1969, p.1.

18. A.B. Hollingshead and F.C. Redlich, Social Class and Mental Illness, New York: John Wiley; 1967, p.vii.

19. Hollingshead and Redlich, ibid., p.172.

20. See for example; E.M. Schur, Labelling Deviant Behavior: Its Sociological Implications, New York: Harper and Row; 1971.

21. J.L. Myers and L.L. Bean, A Decade Later: A Follow-up of Social Class and Mental Illness, New York: John Wiley; 1968.

22. Dohrenwend and Dohrenwend, op.cit., p.5. See also Melvin Kohn, "Class, Family and Schizophrenia: A Reformulation", Social Forces, 50(3), 1972, pp.295-304, for a discussion of issues with respect to the nature of the relationship between class and psychological disorder.

23. Marc Fried, "Social Differences in Mental Health", in J.Kosa et.al.(eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969, p.113.

24. Fried, ibid., p.156.

25. Cade, op.cit., p.138.

26. N. Yeomans and R. Hay, "Psychiatric Epidemiology of Sydney: A Pilot Study", The Medical Journal of Australia, (December 22) 1962, p.988.

27. Krupinski and Stoller, op.cit., p.60.

28. J. Krupinski et.al., A Community Health Survey of the Rural Town of Heyfield, Victoria, Australia, Melbourne: Mental Health Authority Special Publications, No.1, 1970, p.54.

29. Two studies (Cade, and Yeomansand Hay) measured social class in terms of the quality of suburban residence while the other two (both by Krupinski and Stoller) used a ranking of occupations. In the Heyfield study, medical students made the diagnosis, in consultation with psychiatrists and physicians, in the other three projects the assessment was done by psychiatrists. The Heyfield study, concerned with prevalence rates, was a community survey, the other three were investigations of incidence rates based on patient populations of psychiatric agencies.

30. During the planning phase of this project, systematic enquiries were made to determine whether other Australian researchers were working on these problems. The response to these queries revealed that a number of investigations of opinions and attitudes to mental illness were being carried out (for example, by Krupinski and Stoller in Victoria); these will be discussed in some detail later in the report.

31. H. Rodman, "Class Culture", in International Encyclopedia of the Social Sciences, New York: Macmillan; 1968, Vol.15, pp.332-337.

32. Rodman, ibid., p.333.

33. R.W. Hodge and P.M. Siegel, "The Measurement of Social Class", in International Encyclopedia of the Social Sciences, New York: Macmillan; 1968, Vol.15, pp.316-325, and Raymond J. Murphy, op.cit.

34. M.W. Susser and W. Watson, Sociology in Medicine, London: Oxford University Press; 1971, p.105.

35. Susser and Watson, ibid., p.111.

36. Susser and Watson, ibid., p.112.

37. D.W.G. Timms, "Occupational Stratification and Friendship Nomination: A Study in Brisbane", The Australian and New Zealand Journal of Sociology, 3(1), 1967, p.34.

NOTES AND REFERENCES FOR CHAPTER TWO

1. J.E. Edwards and F.A. Whitlock, "Suicide and Attempted Suicide in Brisbane" (i and ii), Medical Journal of Australia, (June 1, 1968), pp.932-938, 989-995.

2. This strategy is analogous to the approach called 'strong inference' in molecular biology and physics: various alternative hypotheses are spelled out for phenomena of interest and studies are devised and performed capable of rejecting the incorrect hypotheses, and the confirmed hypothesis is employed in a repetition of the cycle. John R. Platt, "Strong Inference", Science, 146 (3642), 1964, pp.347-353.

3. An overarching consideration in much of social science research and in survey work in particular, is the limitations imposed by shortages of time, personnel and money. The present study is of course no exception. Clearly, the ideal research design is based on representative samples of the wider Australian public but this was beyond the range of the combined resources of the three investigators in this study.

4. A.B. Hollingshead and F.C. Redlich, Social Class and Mental Illness, New York: John Wiley; 1967.

5. A full list of the hospitals and other treatment facilities will be found in Chapter 4 in which the results of the morbidity study are analyzed.

6. Hollingshead and Redlich, op.cit., p.20.

7. See Appendix 1 for the full patient schedule.

8. Actually there was a brief, third section on road traffic accidents which will not be discussed here.

9. J. Krupinski and A. Stoller, "Occupational Hierarchy of First Admissions to the Victorian Mental Health Department, 1962-1965," The Australian and New Zealand Journal of Sociology, 4(1), 1968, p.62.

10. Krupinski and Stoller, ibid., p.62.

11. In fact this procedure was followed in the community survey carried out in the two suburbs; see Appendix 2 for the occupation item in the questionnaire.

12. The value of pre-tests and pilot studies in survey research is discussed in; W.J. Goode and P.K. Hatt, Methods in Social Research, Tokyo: McGraw-Hill (Kōgakusha); 1967, pp.145-147. The pilot interviews were conducted in suburbs surrounding the University of Queensland; the aim here was to obtain interviews in blue and white collar households, with persons of both sexes and across a range of ages.

13. See Appendix 2 for the complete questionnaire used in the Survey.

14. The Star study is unpublished but considerable details are available in; Joint Commission on Mental Health, Action for Mental Health, New York: John Wiley; 1963, pp.74-77.

15. For example; P.V. Lemkau and G. Crocetti, "An Urban Population's Opinion and Knowledge About Mental Illness", American Journal of Psychiatry, 118(8), 1962, pp.692-698, B.P. Dohrenwend and E. Chin-Song, "Social Status and Attitudes Towards Psychological Disorder: The Problem of Tolerance of Deviance", American Sociological Review, 32(3), 1967, pp.417-433. G.D. Graves, et.al.,"A Survey of Community Attitudes Towards Mental Illness", Australian and New Zealand Journal of Psychiatry, 5(1), 1971, pp.18-28. For a review of the American work, see; H.P. Halpert, "Surveys of Public Opinions and Attitudes About Mental Illness", Public Health Reports, 80(7), 1965, pp.589-597.

16. Dr. Max Harper, Reader in the Department of Psychological Medicine (Queensland University) kindly gave his permission to use the modified versions of the case-abstracts developed in his unpublished research; J. Jordan, B. Earnshaw and M. Harper, "Community Attitudes to Mental Illness", Herston, Brisbane: Department of Psychological Medicine, Queensland University; mimeo, 1972. Importantly, the case-abstracts have been subjected to an external validation by Dohrenwend and Chin-Song - "We asked 34 psychiatrists to make judgements similar to those made about the cases in studies of public attitudes. Almost unanimously, the psychiatrists have seen all six as illustrations of different types of mental disorder"; Dohrenwend and Chin-Song, op.cit., p.420.

17. These case descriptions are illustrative - if not representative samples - of the kinds of disorders seen frequently by psychiatrists (on this point see Dohrenwend and Chin-Song, op.cit., p.420 and Jordan, Earnshaw and Harper, op.cit., 'appendix and author's comments'). Thus they reflect what one author has called "the widening definition of mental disorder" by the mental health professions; H.W. Dunham, "City Core and Suburban Fringe: Distribution Patterns of Mental Illness", in S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, p.340.

18. The diagnosis (e.g. Paranoid schizophrenia) was not included on the card handed to respondents.

19. Dohrenwend and Chin-Song, op.cit., p.422. There is a general discussion of the problems of the order of presentation in; S.A. Stouffer, et.al., Measurement and Prediction, New York: John Wiley; 1966, pp.214-215.

20. D.L. Phillips and B.E. Segal, "Sexual Status and Psychiatric Symptoms", American Sociological Review, 34(1), 1969, pp.58-72. This procedure, of making the stimulus persons in the case-abstracts of the same sex (male), has also been adopted by: R.J. Bord, "Rejection of the Mentally Ill: continuities and further developments", Social Problems, 18(4), 1971, pp.496-509.

21. J. Krupinski et.al., A Community Health Survey of the Rural Town of Heyfield, Victoria, Australia, Melbourne: Mental Health Authority Special Publications; 1970, pp.8-9, J. Krupinski and A. Stoller (eds.) The Health of A Metropolis, Melbourne: Heinemann Educational Books; 1971, pp.8-10.

22. Jerome G. Manis, "The Sociology of Knowledge and Community Mental Health Research", Social Problems, 15(4), 1968, pp.488-501. Actually the term extra-theoretical is originally Karl Mannheim's, as Manis recognizes. Manis is concerned with tracing the role of such factors as the limitations of time, funds, research instruments andmodes of analysis, on the quality and direction of community mental health research.

23. See for example: D. Chappell and P.R. Wilson, The Police and the Public in Australia and New Zealand, Queensland University Press; St. Lucia; 1969.

24. Johan Galtung, Theory and Methods of Social Research, London: George Allen and Unwin; 1970, p.55.

25. The procedures outlined here were in large part a replication of the multi-phase quota sampling approach used by Chappell and Wilson, op.cit., pp.179-182; in that study, the final sample closely approximated the sex, age and occupation distributions of the Australian population.

26. C.A. Moser, Survey Methods in Social Investigation, London: Heinnemann; 1961, pp.127-144. Also, these figures - 2,333 homes approached but only 1,617 households at which people eligible to be interviewed were found - reflect the fact that much interviewing was carried out during the August school vacation (when many families were away) and also during the daytime, when often both husband and wife were at work. However, the Graves et.al., op.cit., study also was faced with the problem of a heavy non-response rate in Melbourne.

27. This was borne out by the comments of some interviewers when they brought back their forms during the Survey, and by remarks made to the writer when he returned to the suburbs to check the validity of the interviews.

28. J.R. Hochstim and K.S. Renne, "Reliability of Response in a Sociomedical Population Study", Public Opinion Quarterly, 35(1), 1971, pp.69-79.

NOTES AND REFERENCES FOR CHAPTER THREE

1. All demographic information in this chapter (unless otherwise specifically stated) is from the Commonwealth Bureau of Census and Statistics. At the time this report was submitted, the only adequate, detailed information available was from the 1966 Census. One publication was particularly useful in preparing this chapter; Commonwealth Bureau of Census and Statistics, Development Within the Brisbane Statistical Division, 1856-1966, Brisbane: mimeo SR83/69.

2. Some information about Carina is available from; Courier-Mail, 26 November, 1964, p.21, and Telegraph, 25 October 1967, p.9.

3. As Faith Thompson points out, few suburbs in modern urban societies have a clear-cut 'territorial base', although all of them (including Carina and The Gap) have government and administrative boundaries - such as postal districts and electoral and statistical boundaries. Faith Thompson, "Suburban Living and the Concept of Community", The Australian and New Zealand Journal of Sociology, 7(2), 1971, pp.23-37.

4. See; Telegraph, 21 July 1966, p.8, and Telegraph, 18 October 1969, p.10.

5. Alvin Boskoff, The Sociology of Urban Regions, New York: Appleton-Century-Crofts; 1970, pp.114-115.

6. Leonard Broom, et.al., "An Occupational Classification of the Australian Workforce", The Australian and New Zealand Journal of Sociology, 1(2), 1965, Supplement.

7. These figures, incidentally, are very close to the religious preferences of the wider Australian public - for example Roman Catholics 26.8%, and Church of England, 33.7%; see K.S. Inglis, "Religious Behavior", in A.F. Davies and S. Encel (eds.) Australian Society: A Sociological Introduction, Melbourne: Cheshire; 1970, pp.437-475.

8. In these tables, and in subsequent tables throughout this report, the percentage total does not always add up to a hundred percent because for convenience, figures have been rounded to the nearest percentage point.

9. Broom, et.al., op.cit.

NOTES AND REFERENCES FOR CHAPTER FOUR

1. A Hollingshead and F.C. Redlich, Social Class and Mental Illness, New York: John Wiley; 1967, p.195.

2. J. Krupinski et.al., A Community Health Survey of the Rural Town of Heyfield, Victoria, Australia, Melbourne: Mental Health Authority Special Publications; 1970, pp.7-8.

3. This line of reasoning has been stated in greater detail by two eminent students of the 'Columbia School', Coleman and Kendall, who argue strongly for the study of trends in data from cross-tabulations rather than the use of significance tests in survey work; James S. Coleman, "Statistical Problems" (Appendix 1B), in S.M. Lipset et.al., Union Democracy, New York: The Free Press; 1956, pp.427-432, and Patricia L. Kendall, "Note on Significance Tests" (Appendix C), in R.K. Merton et.al. (eds.) The Student Physician, Cambridge, Mass.: Harvard University Press; 1957, pp.301-305.

4. The classic work is Faris and Dunham's study of mental disorders in the Chicago urban area. For recent reviews of this research, including replications of the original Faris and Dunham study, see; H. Warren Dunham, "City Core and Suburban Fringe: Distribution Patterns of Mental Illness", in S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, pp.337-363, and D.W.G. Timms, The Urban Mosaic: Towards a Theory of Residential Differentiation, Cambridge: Cambridge University Press; 1971, pp.21-31.

5. Jean I. Martin, "Suburbia: Community and Network", pp.301-339 in A.F. Davies and S. Encel (eds.) Australian Society: A Sociological Introduction, Melbourne: Cheshire; 1970, p.307.

6. Because of typing errors and oversights in checking beyond the writer's control - the Morbidity Census data was collected and coded by research staff from the Department of Psychological Medicine - two items on the pro-forma were unusable; a category was left out of the alternatives supplied for 'length of residence in suburb', and the question on the patient's place of birth read, on some schedules, 'date of birth'. See Appendix 1.

7. On this point see: William Schofield, Psychotherapy: The Purchase of Friendship, Englewood Cliffs, New Jersey: Prentice-Hall; 1964, p.161 and D.L. Phillips and B.E. Segal, "Sexual Status and Psychiatric Symptoms", American Sociological Review, 34(1), 1969, pp.58-72.

8. L. Broom et.al., "An Occupational Classification of the Australian Workforce", Australian and New Zealand Journal of Sociology, 1(2), 1965, Supplement.

9. J. Krupinski and A. Stoller, "Occupational Hierarchy of First Admissions to the Victorian Mental Health Department, 1962-1965", Australian and New Zealand Journal of Sociology, 4(1), 1968, pp.55-63.

10. For example, they will require such information as the occupation and educational levels of both the patient and spouse, household income and the occupation and education of the patient's father. On this point see the questionnaires used and the remarks on the topic by: Hollingshead and Redlich, op.cit., Krupinski et.al., op.cit., and J. Krupinski and A. Stoller (eds.) The Health of a Metropolis, Melbourne: Heinemann Educational Books; 1971.

11. This trend appears for The Gap patients too, where although 6% of the male workforce are described as semi-skilled, no patients are listed as such. The reader will remember that the sample from the door-to-door Survey was underrepresentative of the proportion of semi-skilled workers. It is not likely that this underrepresentation of semi-skilled persons is a coding error; while the modified version of the Broom, Jones and Zubryzcki scheme was used in both instances, different persons did the coding in the Survey and in the Morbidity Census.

12. B. Berelson and G.A. Steiner, Human Behavior: An Inventory of Scientific Findings, New York: Harcourt, Brace and World; 1964, p.639. This point is discussed in; M. Fried, "Social Differences in Mental Health," in J. Kosa et.al.(eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969, pp.113-167. The problem of the reliability of psychiatric diagnosis discussed above in this context, is considered by; P.W. Haberman, "The Reliability and Validity of the Data", in Kosa, et.al. (eds.) ibid., pp.343-383.

13. Because of the small numbers involved, it was necessary to combine professionals, managers, and clerical-sales workers into a single (white collar) category for the purpose of analysis. An inspection of the data revealed that these occupational groups had very similar patterns of psychiatric diagnosis and that it would be quite appropriate and meaningful to combine them into a single group. Later, in the analysis of the Survey data, sufficiently large numbers permit a breakdown into three groups - professionals and managers, clerical and sales workers, and manual workers - for a more sophisticated analysis of the influence of socio-economic status. For a recent research report in which this was done, see; J.S. Western and C.A. Hughes, The Mass Media in Australia, St. Lucia, Brisbane: University of Queensland Press; 1971, pp.28-29.

14. Raymond J. Murphy, "Stratification and Mental Illness: Issues and Strategies for Research", in Plog and Edgerton (eds.) op.cit., p.323. See also Berelson and Steiner, op.cit., and Fried, op.cit., p.113, who argues strongly that "the evidence is unambiguous and powerful that the lowest social classes have the highest rates of severe psychiatric disorder in our society," (U.S.A.). An Australian study reports higher incidence rates for alcoholism, schizophrenic states and personality disorders in semi-skilled and unskilled workers: Krupinski and Stoller, op.cit., 1968.

15. Timms, op.cit., p.14.

16. D.C. Leighton, et.al. The Character of Danger: Psychiatric Symptoms in Selected Communities, New York: Basic Books; 1963, pp.379-381.

17. A. Stoller, "The Origin of the Survey", in Krupinski and Stoller (eds.) op.cit., 1971, p.4.

18. Dunham, op.cit., pp.350-351.

19. In a later stage of the project, depending on resources of time and money, it is intended to analyze fully the data (already collected) on crime and delinquency rates, suicide and attempted suicide, and motor vehicle accidents from the two suburbs. It is suggested that looking at the prevalence data in relation to these other phenomena will prove a fruitful exercise.

20. Clausen is quoted in J.M. Yinger, Towards a Field Theory of Behaviour, New York: McGraw-Hill; 1965, p.285. See also Yinger's discussion on p.213 and p.237.

21. For a review of the role of social class factors in the treatment of mental disorder, see: F. Riessman, et.al. (eds.) Mental Health of the Poor, New York: The Free Press; 1966. A Brisbane study conducted by the writer revealed interesting differences between blue and white collar clients of a voluntary social welfare agency with respect to the types of problem they brought to the agency and the duration of treatment (white collar clients were most likely to have problems needing 'counselling' and they tended to stay in treatment longer than blue collar clients, who were more likely to make a request for practical help): S. Gardan, A. Pemberton and V. Graham, Kalparrin: A Voluntary Agency Looks to Itself, St. Lucia, Brisbane: University of Queensland Press; 1972, pp.141-142.

22. The rationale used in the construction of this table was the same as that used in Table 4.07; see note 13 of this chapter.

23. Fried, op.cit., pp.155-158.

24. Liberman offers a preliminary analysis of the 'gatekeeper' role of physicians in psychiatric referral: Robert Liberman, "The Part Played by Physicians in the Patient's Path to the Mental Hospital", Community Mental Health Journal, 3(4), 1967, pp.325-330.

25. For example, see: Hollingshead and Redlich, op.cit., and the follow-up study, J.K. Myers and L.L. Bean, A Decade Later: a follow-up of Social Class and Mental Illness, New York: John Wiley; 1968.

26. Hollingshead and Redlich, op.cit., pp.171-172.

NOTES AND REFERENCES FOR CHAPTER FIVE

1. The case-histories (described in Chapter Two in full) were shown to respondents on cards, while at the same time, the interviewer read them aloud.

2. Ray Bord, "Rejection of the Mentally Ill: Continuities and Further Developments", Social Problems, 18(4), 1971, pp.496-509.

3. See Gwen D. Graves et.al., "A Survey of Community Attitudes Towards Mental Illness", Australian and New Zealand Journal of Psychiatry, 18(5), 1971, pp.18-28. This article provides a useful synoptic account of the studies using fictitious case-histories, from the earliest American work in the 1950s to recent research in Japan and New Zealand.

4. Graves, et.al., ibid., p.25.

5. Graves, et.al., ibid., p.25.

6. In passing, it is certainly worth mentioning the surprisingly large numbers of respondents - 28% from Carina and 22% from The Gap - who spontaneously volunteered "Alcoholics Anonymous" as the appropriate source of help for the alcoholic.

7. David Mechanic, Mental Health and Social Policy, New Jersey: Prentice-Hall; 1969, pp.65-78. On psychiatric treatment and the mental hygiene movement, see: W. Schofield, Psycho-therapy: The Purchase of Friendship, New Jersey: Prentice-Hall; 1964.

8. For a discussion of the widening definition of mental illness within the mental hygiene movement to include the "minor emotional disturbances", see: H. Warren Dunham, "City Core and Suburban Fringe: Distribution Patterns of Mental Illness", in S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, pp.337-363.

9. J. Jordan, B. Earnshaw and M. Harper, "Community Attitudes to Mental Illness", Herston: Department of Psychological Medicine, Queensland University; mimeo, 1972, p.22.

10. Jordan, Earnshaw and Harper, ibid., p.21.

11. The item-total correlations were calculated using the procedure recommended by Guilford to determine the extent to which there was a correlation between item score, and total score: J.P. Guilford, Fundamental Statistics in Psychology and Education, Tokyo: McGraw-Hill (Kōgakusha); 1956, pp.326-328.

12. There are two observations to be made about this procedure. First, because of the skewed distribution of responses to some of the cases, dichotomization of these items could only be approximated. Second, a clerical error resulted in the items being dichotomized so that 'positive' responses were scored zero, rather than 1, with the result that high scorers are 'low' on the scale. These points apply to the construction of the recognition of mental illness scale, also.

13. 'High' scorers on the scale (0, 1, 2) formed one group, the 'mediums' (3, 4, 5) another and the 'lows' were scorers of 6, 7 and 8. The distribution of scores on the scale for the two suburbs was: "high" scores; Carina 23%, The Gap 21%, "mediums"; 54% and 58%, "low" scores; 22% Carina and 22% The Gap. In other words, there were no differences between the suburbs on scale 'scores' for the evaluation of seriousness index.

14. For the two suburbs the 'scores' were: "high"; Carina 16% The Gap 15%; "medium"; 68% and 66%, "low" scores; Carina 16% and The Gap 19%. Once again there were no suburban differences.

15. The relationship between scores on the two scales is discussed in Appendix 4.

16. Graves et.al. op.cit., and Jordan, Earnshaw and Harper, op.cit.

17. Jordan, Earnshaw and Harper, ibid., p.13.

18. See Graves et.al., op.cit., Jordan, Earnshaw and Harper, op.cit., and B.P. Dohrenwend and B.S. Dohrenwend, Social Status and Psychological Disorder: A Causal Inquiry, New York: John Wiley; 1969, pp.151-164.

19. F.C. Redlich and D.X. Freedman, The Theory and Practice of Psychiatry, New York: Basic Books; 1966, p.298. Underpinning the mental hygiene movement is the aim to ensure that the appropriate treatment is obtained, as soon as possible, in either a psychiatric clinic, mental hospital or some other mental hygiene agency.

20. Telegraph, 14 September, 1971, p.13.

21. Ibid., p.13.

22. Peter H. Rossi and Zahava D. Blum, "Class, Status and Poverty", pp.36-63 in D.P. Moynihan (ed.) On Understanding Poverty, New York: Basic Books; 1969, p.53.

23. The original paper by Kingsley Davis was published in 1938, and work has since been done by, for example, Gursslin, Hunt and Roach; see O.R. Gursslin et.al., "Social Class and the Mental Health Movement", in F. Riessman et.al. (eds.) Mental Health of the Poor, New York: The Free Press; 1966, pp.57-67.

24. T.J. Scheff, Being Mentally Ill: A Sociological Theory, Chicago: Aldine; 1966.

25. W.R. Gove, "Societal Reaction as an Explanation of Mental Illness: An Evaluation", American Sociological Review, 35(5), 1970, pp.873-884.

NOTES AND REFERENCES FOR CHAPTER SIX

1. David Mechanic, Medical Sociology: a selective view, New York: The Free Press; 1968, especially Chapter 4, and D. Mechanic, Mental Health and Social Policy, Englewood Cliffs, New Jersey; Prentice-Hall; 1969, Chapter 5.

2. Mechanic, op.cit., 1968, p.116.

3. For example, see D. Rosenblatt and E.A. Suchman, "Blue-Collar Attitudes and Information Toward Health and Illness", in A.B. Shostak and W. Gomberg (eds.) Blue-Collar World: studies in the American worker, Englewood Cliffs, New Jersey: Prentice-Hall; 1964, pp.324-333.

4. Mechanic, op.cit., 1968, p.150. Similarly, Kadushin, in his detailed and systematic study, only has a few lines on the topic (though he appears to recognize its importance); "Information-gathering may be the most crucial element in the final stage" (of finding a psychiatrist). "Individual psychotherapists and psychiatric clinics are quite unknown to the general public, and merely finding a good therapist (or any therapist) is a serious problem for potential psychiatric patients". Charles Kadushin, Why People Go to Psychiatrists, New York: Atherton Press; 1969, p.315.

5. It is very likely that these differences express the greater likelihood of residents of the middle class area, The Gap, being members of a subsidized, contributory health scheme which requires that consultation with a specialist (such as a psychiatrist) be referred through a general practitioner.

6. Kadushin, op.cit., p.315.

7. The two questions used were: (1) "What about a husband and wife having marital difficulties? If they were friends of yours, would you be able to tell them where they could receive help if they asked you?" (2) "Now, imagine you were in financial difficulties. Would you know where to go for help?"

8. For example, see L.H. Day, "Divorce", in A.F. Davies and S. Encel (eds.) Australian Society: A Sociological Introduction, Melbourne: Cheshire; 1970, pp.292-300, R.F. Henderson, A. Harcourt and R. Harper, People in Poverty: a Melbourne Survey, Melbourne: Cheshire; 1970, and P.R. Wilson (ed.) Australian Social Issues of the 70's, Sydney: Butterworths; 1972, especially pp.171-199.

9. The role of informal resources, such as family and friends, in times of financial hardship has been explored in a preliminary way in a British study: John E. Mayer and Noel Timms, The Client Speaks: Working Class Impressions of Casework, London: Routledge and Kegan Paul; 1970, especially pp.37-51 and pp.99-105.

10. Mechanic, op.cit., 1968, p.150.

11. For a discussion of class differences in exposure to the mass media, see P. Rossi and Zahava Blum, "Class, Status, and Poverty", in D.P. Moynihan (ed.) On Understanding Poverty, New York: Basic Books; 1969, pp.36-63.

12. Marc Fried provides an excellent discussion of class biases in the social and professional responses to psychological malfunctioning; Marc Fried "Social Differences in Mental Health" in J. Kosa et.al. (eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969, pp.113-167 and see especially pp.156-158.

13. To overcome the problem of small numbers, the data analysis included treating persons from Carina and The Gap as a single group in an endeavour to discover trends.

14. Howard B. Kaplan, "Mental Illness as a Social Problem", in E.O. Smigel (ed.) Handbook on the Study of Social Problems, Chicago: Rand McNally; 1971, p.342.

15. This problem is discussed in a general way in F. Riessman et.al.(eds.) Mental Health of the Poor, New York: The Free Press; 1964, pp.57-109. For comments on the Australian situation, see B. Hennessy, "Social Implications in Community Health Programmes", in H. Weir (ed.) Social Welfare in the 1970's, Sydney: Australian Council of Social Services; 1970, pp.101-104, and Wilson, op.cit., see especially pp.171-174.

16. The Brisbane metropolitan area is well served by radio and television information programmes (including one devoted to mental health and social problems), and newspaper advice columns regularly deal with advice and information about socio-emotional and financial problems. However, as Schur has recently pointed out, there is an important distinction to be made between mass media coverage of documentary and 'service' type programmes about mental illness and other social problems, and media presentation of the bizarre and exageratedly negative aspects of these phenomena: see E. Schur, Labelling Deviant Behaviour: Its Sociological Implications, New York: Harper and Row; 1971, pp.45-48.

17. G.A. Almond and S. Verba, The Civic Culture: Political Attitudes and Democracy in Five Nations, Boston: Little, Brown and Company; 1965, especially chapters 2, 6 and 7.

18. A.B. Hollingshead and F.C. Redlich, Social Class and Mental Illness, New York: John Wiley; 1967, p.130, and see also p.176 and p.181.

19. The three questions were; "Have you ever known anyone who was in hospital because of mental or nervous illness?" "Have you ever known anyone who has sought help from a doctor or psychiatrist for mental or nervous illness?" "Has any member of this household ever needed to seek medical help for a mental or nervous illness?"

20. These data and the cross-tabulations based on contact with the mentally ill have not been included in tabular form because of limitations of space.

21. M. Wadsworth, W. Butterfield and R. Blaney, Health and Sickness: The Choice of Treatment, London: Tavistock Publications; 1971, L.C. Kolb et.al.(eds.) Urban Challenges to Psychiatry: The Case History of a Response, Boston: Little, Brown and Company; 1969 and A. Bindman and A. Spiegel (eds.) Perspectives in Community Mental Health, Chicago: Aldine; 1969. The criticism applies also to studies done closer to home; J. Krupinski et.al. A Community Health Survey of the Rural Town of Heyfield, Victoria, Australia, Melbourne: Mental Health Authority Special Publications No.1; 1970, see especially the discussion on pp.71-72.

NOTES AND REFERENCES FOR CHAPTER SEVEN

1. S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, pp.285 and 395. A similar theme was echoed in an Australian context: "Man responds to stresses in his environment, both physical and mental, with varying degrees of adaptation. Where social conditions are inadequate, health tends to suffer... loneliness, the unknown numbers of people desperately needing help, the difficulties of life in flats, migrant integration, the language barrier, provision of care for young children, the problems of deserted wives and widows, transport, housing, employment, and many others... and of course, the health problems arising either de novo or out of the circumstances." A. Stoller, "The Origin of the Survey" in J. Krupinski and A. Stoller (eds.) The Health of the Metropolis, Melbourne: Heinemann Educational Books; 1971, p.5.

2. H. Kaplan, "Mental Illness as a Social Problem", in E.O. Smigel (ed.) Handbook on the Study of Social Problems, Chicago: Rand McNally; 1971, p.334.

3. M. Fried, "Social Differences in Mental Health", in J. Kosa, et.al.(eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969, p.113.

4. A.B. Hollingshead and F.C. Redlich, Social Class and Mental Illness, New York: John Wiley; 1967, p.358.

5. J. Krupinski and A. Stoller, "Occupational Hierarchy of First Admissions to the Victorian Mental Health Department, 1962-1965", The Australian and New Zealand Journal of Sociology, 4(1), 1968, pp.61-62. This point of course raises the general issue of the interrelation of cause and effect in studies of class and mental illness, see: B.P. Dohrenwend and B.S. Dohrenwend, Social Status and Psychological Disorder, New York: John Wiley; 1969, especially pp.1-7.

6. Hollingshead and Redlich, op.cit., pp.358-360. The issue has been taken up again and more recently by Raymond Murphy who suggests studies of "the dynamics of the process or processes by which persons come to develop, or escape developing, symptoms of mental disturbance. Specifically, what is the role of structural position in the etiology of mental disorder? How do conditions of structure impinge upon the individual so as to cause him (or precipitate him) to develop clinical symptoms of disturbance?" R. Murphy, "Stratification and Mental Illness: Issues and Strategies for Research", in Plog and Edgerton, op.cit., p.323.

7. T.J. Scheff, Being Mentally Ill: A Sociological Theory, Chicago: Aldine; 1966.

8. W.J. Bruen and B.L. Hennessy, "Patterns in the Geographical Distribution of Referrals to Social and Health Agencies Within a Municipality," Australian Journal of Social Issues, 5(2), 1970, p.157.

9. It is not intended to become involved here in an assessment of the worth of general practitioners in handling problems of social and psychological pathology. There seems to be two schools of thought on the matter: on the one hand, those who say that, because of their intimate knowledge of local families, general practitioners are very well placed to engage in treatment of the minor neuroses and to do some limited counselling, while referring the more serious cases to specialist care; the other view is that because of their lack of sophistication and training in psychiatric matters, general practitioners miss many serious cases that require referral and they are poorly equipped to give any kind of advice or counselling - as well, it is often suggested that they are responsible for considerable misuse (through over-prescription) of minor tranquilizers and hypnotics such as the barbiturates.

10. L. Bryson and F. Thompson, An Australian Newtown, Ringwood, Victoria: Penguin Books; 1972, p.259.

11. B.S. Hetzel, J.Krupinski and A. Stoller, "Summary and Conclusions", in Krupinski and Stoller, op.cit., 1971, p.87.

12. R.B. Burnheim, "Development of a Research and Evaluation Service in a Regionalized State Mental Health Service: Rationale, Strategy and Implementation", mimeographed (Paper presented to the Fifth Annual Conference of the Australian Psychological Society, Hobart, August, 1970), p.5.

13. Burnheim, ibid., p.5.

14. Hetzel, Krupinski and Stoller, op.cit., p.87.

15. F. Riessman, et.al.(eds.) Mental Health of the Poor, New York: The Free Press; 1966, pp.8-9. The ideas of Davis, and a research study by Gursslin, Hunt and Roach are discussed in this source.

16. H.E. Freeman and C.C. Sherwood, Social Research and Social Policy, Englewood Cliffs, New Jersey: Prentice-Hall; 1970, p.1.

BIBLIOGRAPHY

Almond, G.A. and Verba, S. The Civic Culture: Political Attitudes and Democracy in Five Nations, Boston: Little, Brown and Co.; 1965.

Bahn, A.K. 'An Outline for Community Mental Health Research', Community Mental Health Journal, 1(1), 1965, pp.23-28.

Bastide, R. The Sociology of Mental Disorder, London: Routledge and Kegan Paul; 1972.

Berelson, B. and Steiner, G.A. Human Behaviour: An Inventory of Scientific Findings, New York: Harcourt, Brace and World; 1964.

Bindman, A.J. and Spiegel, A.D. (eds.) Perspectives in Community Mental Health, Chicago: Aldine; 1969.

Bord, R.J. 'Rejection of the Mentally Ill: Continuities and Further Developments', Social Problems, 18(4), 1971, pp.496-509.

Boskoff, A. The Sociology of Urban Regions, New York: Appleton-Century-Crofts; 1970.

Broom, L. et.al. 'An Occupational Classification of the Australian Workforce', The Australian and New Zealand Journal of Sociology, 1(2), 1965, Supplement.

Bruen, W.J. and Hennessy, B.L. 'Patterns in the Geographical Distribution of Referrals to Social and Health Agencies Within a Municipality', Australian Journal of Social Issues, 5(2), 1970, pp.150-159.

Bryson, L. and Thompson, F. An Australian Newtown, Ringwood, Victoria: Pelican Books; 1972.

Burnheim, R.B. 'Development of a Research and Evaluation Service in a Regionalized State Mental Health Service: Rationale, Strategy and Implementation', mimeographed (Paper presented to the Fifth Annual Conference of the Australian Psychological Society, Hobart, August, 1970).

Cade, J.F.J. 'The Aetiology of Schizophrenia', Medical Journal of Australia, July 28, 1956, pp.135-139.

Chappell, D. and Wilson, P.R. The Police and the Public in Australia and New Zealand, St. Lucia, Brisbane: Queensland University Press; 1969.

Clausen, J.A. 'Mental Disorders', in R.K. Merton and R.A. Nisbet (eds.) Contemporary Social Problems, New York: Harcourt, Brace and World; 1966, pp.26-83.

Coleman, J.S. 'Statistical Problems', in S.M. Lipset et.al., Union Democracy, New York: The Free Press; 1956, (Appendix IB), pp.427-432.

Commonwealth Bureau of Census and Statistics, Development Within the Brisbane Statistical Division 1856-1966, Brisbane: mimeo, SR83/69.

Cooper, D. Psychiatry and Anti-Psychiatry, London: Tavistock; 1967.

Courier-Mail, 26 November 1964.

Day, L.H. 'Divorce', in A.F. Davies and S. Encel (eds.) Australian Society: A Sociological Introduction, Melbourne: Cheshire; 1970, pp.292-300.

Dohrenwend, B.P. and Dohrenwend, B.S. Social Status and Psychological Disorder, New York: John Wiley; 1969.

Dohrenwend, B.P. and Chin-Song, E. 'Social Status and Attitudes Towards Psychological Disorder: The Problem of Tolerance of Deviance', American Sociological Review, 32(3), 1967, pp.417-433.

Dufrancatel, C. 'La Sociologie Des Maladies Mentales', Current Sociology, 15(2), 1968, pp.5-69.

Dunham, H.W. 'City Core and Suburban Fringe: Distribution Patterns of Mental Illness', in S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, pp.337-363.

Edwards, J.E. and Whitlock, F.A. 'Suicide and Attempted Suicide in Brisbane', (I and II) Medical Journal of Australia, June 1, 1968, pp.932-938 and pp.989-995.

Ford, P. 'Libertarian Psychiatry: An Introduction to Existential Analysis', Anarchy 70, 6(12), 1966, pp.353-374.

Freeman, H.E. and Sherwood, C.C. Social Research and Social Policy, Englewood Cliffs, New Jersey: Prentice-Hall; 1970.

Fried, M. 'Social Differences in Mental Health', in J. Kosa et.al. (eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969, pp.113-167.

Galtung, J. Theory and Methods of Social Research, London: George Allen and Unwin; 1970.

Gardan, S. et.al. Kalparrin: A Voluntary Agency Looks to Itself, St. Lucia, Brisbane: University of Queensland Press; 1972.

Goode, W.J. and Hatt, P.K. Methods in Social Research, Tokyo: McGraw-Hill (Kōgakusha); 1967.

Gove, W.R. 'Societal Reactions as an Explanation of Mental Illness: An Evaluation', American Sociological Review, 35(5), 1970, pp.873-884.

Graves, D. et.al. 'A Survey of Community Attitudes Towards Mental Illness', Australian and New Zealand Journal of Psychiatry, 5(1), 1971, pp.18-28.

Guilford, J.P. Fundamental Statistics in Psychology and Education, Tokyo: Kōgakusha (McGraw-Hill); 1956.

Gursslin, O.R. et.al.'Social Class and the Mental Health Movement', in F. Riessman et.al. (eds.) Mental Health of the Poor, New York: The Free Press; 1966, pp.57-67.

Haberman, P.W. 'The Reliability and Validity of the Data', in J. Kosa et.al.(eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969, pp.343-383.

Halpert, H.P. 'Surveys of Public Opinions and Attitudes About Mental Illness', Public Health Reports, 80(7), 1965, pp.589-597.

Henderson, R.F. et.al. People in Poverty: A Melbourne Survey, Melbourne: Cheshire; 1970.

Hennessy, B.F. 'Social Implications in Community Health Programmes', in H. Weir (ed.) Social Welfare in the 1970s, Sydney: Australian Council of Social Services; 1970, pp.101-104.

Hetzel, B.S. et.al. 'Summary and Conclusions', in J. Krupinski and A. Stoller (eds.) The Health of a Metropolis, Melbourne: Heineman Educational Books; 1971, pp.82-88.

Hochstem, J.R. and Renne, K.S. 'Reliability of Response in a Socio-Medical Population Study', Public Opinion Quarterly, 35(1), 1971, pp.69-79.

Hodge, R.W. and Siegel, P.M. 'The Measurement of Social Class', in International Encyclopedia of the Social Sciences, New York: Macmillan; 1968, Vol.15, pp.316-325.

Hollingshead, A.B. and Redlich, F.C. Social Class and Mental Illness, New York: John Wiley; 1967.

Inglis, K.S. 'Religious Behaviour', in A.F. Davies and S. Encel(eds.) Australian Society: A Sociological Introduction, Melbourne: Cheshire; 1970, pp.437-475.

Joint Commission on Mental Health, Action for Mental Health, New York: John Wiley; 1963.

Jordan, J. et.al. 'Community Attitudes to Mental Illness', (Herston, Brisbane: Department of Psychological Medicine, Queensland University; mimeo, 1972).

Kadushin, C. Why People Go To Psychiatrists, New York: Atherton Press; 1969.

Kaplan, H.B. 'Mental Illness as a Social Problem', in E.O. Smigel (ed.) Handbook On The Study of Social Problems, Chicago: Rand McNally; 1971, pp.331-365.

Kendall, P.L. 'Note on Significance Tests', in R.K. Merton et.al.(eds.) The Student Physician, Cambridge, Mass.: Harvard University Press; 1957, (Appendix C), pp.301-305.

Kohn, M. 'Class, Family, and Schizophrenia: A Reformulation', Social Forces, 50(3), 1972, pp.295-304.

Kolb, L. et.al.(eds.) Urban Challenges to Psychiatry: The Case History of a Response, Boston: Little, Brown and Co.; 1969.

Kosa, J. et.al.(eds.) Poverty and Health: A Sociological Analysis, Cambridge, Mass.: Harvard University Press; 1969.

Krupinski, J. and Stoller, A. 'Occupational Hierarchy of First Admissions to the Victorian Mental Health Department, 1962-1965', The Australian and New Zealand Journal of Sociology, 4(1), 1968, pp.55-63.

Krupinski, J. et.al. A Community Health Survey of the Rural Town of Heyfield, Victoria, Australia, Melbourne: Mental Health Authority Special Publications; No.1, 1970.

Krupinski, J. and Stoller, A. (eds.) The Health of a Metropolis, Melbourne: Heineman Educational Books; 1971.

Laing, R.D. The Politics of Experience, Ringwood, Victoria: Penguin Books; 1972.

Leighton, D.C. et.al. The Character of Danger: Psychiatric Symptoms in Selected Communities, New York: Basic Books; 1963.

Lemkau, P.V. and Crocetti, G. 'An Urban Population's Opinions and Knowledge About Mental Illness', American Journal of Psychiatry, 118(8), 1962, pp.692-698.

Liberman, R. 'The Part Played by Physicians in the Patient's Path to the Mental Hospital', Community Mental Health Journal, 3(4), 1967, pp.325-330.

Manis, J.G. 'The Sociology of Knowledge and Community Mental Health Research', Social Problems, 15(4), 1968, pp.488-501.

Martin, J.I. 'Suburbia: Community and Network', in A.F. Davies and S. Encel(eds.) Australian Society: A Sociological Introduction, Melbourne: Cheshire; 1970, pp.301-339.

Mayer, J. and Timms, N. The Client Speaks: Working Class Impressions of Casework, London: Routledge and Kegan Paul; 1970.

Mechanic, D. 'Some Factors in Identifying and Defining Mental Illness', Mental Hygiene, 46(1), 1962, pp.66-74.

Mechanic, D. Medical Sociology: A Selective View, New York: The Free Press; 1968.

Mechanic, D. Mental Health and Social Policy, Englewood Cliffs, New Jersey: Prentice-Hall; 1969.

Moser, C.A. Survey Methods in Social Investigation, London: Heinemann; 1961.

Murphy, R.J. 'Stratification and Mental Illness: Issues and Strategies for Research', in S.C. Plog and R.B. Edgerton (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969, pp.313-356.

Myers, J.L. and Bean, L.L. A Decade Later: A Follow-Up of 'Social Class and Mental Illness', New York: John Wiley; 1968.

Phillips, D.L. and Segal, B.E. 'Sexual Status and Psychiatric Symptoms', American Sociological Review, 34(1), 1969, pp.58-72.

Platt, J.R. 'Strong Inference', Science, 146(3,642), 1964, pp.347-353.

Plog, S.C. and Edgerton, R.B. (eds.) Changing Perspectives in Mental Illness, New York: Holt, Rinehart and Winston; 1969

Pilowsky, I. and Maddison, D.(eds.) Psychiatry and the Community, Sydney: Sydney University Press; 1969.

Rabkin, J.G. 'Opinions About Mental Illness: A Review of the Literature', Psychological Bulletin, 77(3), 1972, pp.153-171.

Ray, J.J. 'The Questionnaire Measurement of Social Class', The Australian and New Zealand Journal of Sociology, 7(1), 1971, pp.58-64.

Redlich, F.C. and Freedman, D.X. The Theory and Practice of Psychiatry, New York: Basic Books; 1966.

Riessman, F. et.al.(eds.) Mental Health of the Poor, New York: The Free Press; 1966.

Robinson, D. The Process of Becoming Ill, London: Routledge and Kegan Paul; 1971.

Rodman, H. 'Class Culture' in International Encyclopedia of Social Science, New York: Macmillan; 1968, Vol.15, pp.332-337.

Rosenblatt, D. and Suchman, E.A. 'Blue Collar Attitudes and Information Towards Health and Illness', in A.B. Shostak and W. Gomberg (eds.) Blue Collar World: Studies in the American Worker, Englewood Cliffs, New Jersey: Prentice-Hall; 1964, pp.324-333.

Rossi, P. and Blum, Z. 'Class, Status, and Poverty', in D.P. Moynihan (ed.) On Understanding Poverty, New York: Basic Books; 1969, pp.36-63.

Scheff, T.J. Being Mentally Ill: A Sociological Theory, Chicago: Aldine; 1966.

Scheff, T.J. (ed.) Mental Illness and Social Processes, New York: Harper and Row; 1967.

Schofield, W. Psychotherapy: The Purchase of a Friendship, Englewood Cliffs, New Jersey: Prentice-Hall; 1964.

Schur, E.M. Labelling Deviant Behavior: Its Sociological Implications, New York: Harper and Row; 1971.

Stoller, A. 'The Origins of the Survey', in J. Krupinski and A. Stoller (eds.) The Health of a Metropolis, Melbourne: Heinemann Educational Books; 1971, pp.1-6.

Stouffer, S.A. et.al. Measurement and Prediction, New York: John Wiley; 1966.

Susser, M.W. and Watson, W. Sociology in Medicine, London: Oxford University Press; 1971.

Szasz, T.S. 'The Myth of Mental Illness', in T.J. Scheff (ed.) Mental Illness and Social Processes, New York: Harper and Row; 1967, pp.242-254.

Taber, M. et.al. 'Disease Ideology in Mental Health Research', Social Problems, 16(3), 1969, pp.349-357.

Telegraph, 21 July, 1966.

Telegraph, 25 October, 1967.

Telegraph, 18 October, 1969.

Telegraph, 14 September, 1971.

Thompson, F. 'Suburban Living and the Concept of Community, The Australian and New Zealand Journal of Sociology, 7(2), 1971, pp.23-37.

Timms, D.W.G. 'Occupational Stratification and Friendship Nomination: A Study in Brisbane', The Australian and New Zealand Journal of Sociology, 3(1), 1967, pp.32-43.

Timms, D.W.G. The Urban Mosaic: Towards a Theory of Residential Differentiation, Cambridge: Cambridge University Press; 1971.

Wadsworth, M. et.al. Health and Sickness: The Choice of Treatment, London: Tavistock; 1971.

Western, J.S. and Hughes, C.A. The Mass Media in Australia, St. Lucia, Brisbane: University of Queensland Press; 1971.

Wilson, P.R. (ed.) Australian Social Issues of the 70's, Sydney: Butterworths; 1972.

Yeomans, N. and Hay, R. 'Psychiatric Epidemiology of Sydney: A Pilot Study', Medical Journal of Australia, December 22, 1962, pp.986-989.

Yinger, J.M. Towards a Field Theory of Behavior, New York: McGraw-Hill; 1965.

Zola, I.K. 'Illness Behavior of the Working Class', in A.B. Shostak and W. Gomberg (eds.) Blue Collar World: Studies in the American Worker, Englewood Cliffs, New Jersey: Prentice-Hall; 1964, pp.350-361.